11/12/13 e 1530 spoke to [redacted] Accepted POC. [redacted]

DEPARTMENT OF HEALTH AND HUM[illegible] SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCT[redacted]	(X3) DATE SURVEY COMPLETED
	555363	A. BUILDING _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN GLEN SKILLED NURSING	2671 PLUMMER AVENUE SAN JOSE, CA 95125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
DEPART CENTE	F000 INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a recertification survey conducted from 10/22/13 through 10/25/13. The facility was licensed for 59 beds. The census at the time of the survey was 55. The sample size was 14. Representing the California Department of Public Health: 32398, Health Facilities Evaluator Nurse, 17536, Health Facilities Evaluator Nurse, and 33087, Health Facilities Evaluator Nurse.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156	**F156** The appropriate phone numbers and the staff person who can assist with receiving a Medicare and/or Medicaid refund were posted on 11/7/13. 11/7/13 The facility consumer board was reviewed and revised to ensure that all required information is available. 11/7/13 An audit of the consumer board will be conducted quarterly by Medical Records and Office Manager to ensure that all required consumer information remains posted. Any discrepancies will be reported to the Administrator for review and correction. ON-GOING	

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
NOV 12 2013
L & C DIVISION

LABORATORY DIRECTOR'S OR PRO[redacted] 11/11/13

Any deficiency statement ending wi[redacted] other safeguards provide sufficient [redacted] following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Accepted POC with

DEPARTMENT OF HEALTH AND HUMAN SERVICES [redacted]
CENTERS FOR MEDICARE & MEDICAID SERVICES [redacted] V 13 2013

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	555363	A. BUILDING on 11/14/13 @ 11:20 AM L & C DIVISION SAN JOSE B. WING [redacted] for	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN GLEN SKILLED NURSING	2671 PLUMMER AVENUE [redacted] SAN JOSE, CA 95125

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE (X6) DATE 11/11/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 156	Continued From page 1 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification	F 156	**F166** The Social Services Director (SSD) met with resident 6 to discuss her concerns and review the facility's grievance procedure. Resident was reminded that time in resident care conference can also be utilized to discuss concerns. SSD will review Grievance Procedure and noise levels with residents during Resident Council Meetings quarterly. Assistant Administrator will review Grievance Procedure with residents during monthly QAPI Resident Meeting. Facility Staff will conduct investigations and provide follow-up reports on all concerns as indicated. QAPI Performance Improvement Project (PIP)	11/11/13 ON-Going

CALIFORNIA DEPARTMENT
OF PUBLIC HEALTH
NOV 13 2013
L & C DIVISION
SAN JOSE

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post information as to how to receive refunds for previous Medicare/Medicaid payments made. Findings: During review of mandatory federal postings on 10/23/13, a posting was not found as to how to receive refunds for previous Medicare/Medicaid payments. During an interview on 10/23/13 at 8 a.m., the director of nursing and the medical records coordinator stated they did not see a posting related to refunds for Medicare/Medicaid payments.	F 156	will be established as required to ensure proper systems are evaluated and modified in order to ensure resident satisfaction. Families and responsible parties will be notified of Grievance Policy annually in the year end letter from Assistant Administrator. ON-Going The Grievance Policy and Procedure will be reviewed and revised by Assistant Administrator to ensure that the procedures in place are implemented appropriately. 11/15/13 All Lincoln Glen Staff will be inserviced on Lincoln Glen's Grievance Policy and Procedure by Director of Staff Development & DON. 11/4/13	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	F 166		

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F 166	Continued From page 3 A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow-up on a noise grievance for one of 14 residents (6). In January 2013, Resident 6 had complained to staff about noise on the night shift but had never heard back from the facility. Findings: During an interview on 10/24/13 at 9 a.m., Resident 6 stated that shift change for night shift was too noisy. She stated in January 2013, she told the social service director (SSD) during a resident council meeting, but the noise level had not changed and the SSD never brought her any information of attempts for a resolution. During an interview on 10/24/13 at 10:45 a.m., the SSD stated after a resident had brought a complaint about the noise level at shift change for night shift, she spoke to the director of nurses (DON). She was not able to find any notes regarding the grievance in the minutes for any of the resident council meetings after January, or of her getting back to Resident 6 about her grievance. During an interview on 10/24/13 at 11 a.m., the DON asked the SSD what was her response in the minutes for the resident council meeting. SSD stated she did not write it down. After looking in her notes she stated she could not find any	F 166	**F 279** Statement: F483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS It is the policy of Lincoln Glen Skilled Nursing Facility to develop, review and revise a plan of care for each resident. Identified corrective action: Post fall reviews had been completed with new approaches identified after each of the listed falls for Resident 6 and 8. On 11/4/13 the care plans of both residents were updated to reflect the approaches that had been put in place. Resident 9's care plan was updated by the Social Services Director to reflect	11/4/13

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F 166	Continued From page 4 indication any attempt at resolution was implemented. The SSD was unable to find any indication of the noise grievance in her grievance binder. A review on 10/25/13 of the facility's 5/20/05 "Grievance Policy and Procedure" indicated the facility will make prompt efforts to resolve grievance or explain why the facility cannot reasonably resolve the problem. The Administrator or designee will give an oral report to the person filing the grievance or complaint within ten working days of the initial filing of the grievance. A written summary will also be provided, and a copy will be filed in the business office.	F 166	approaches that had been put in place on 10/25/13. Rsdt 9 had been referred to psychology services on 9/30/13. His initial visit with the psychologist was on 10/8/13 and he has had subsequent appointments as well.	10/25/13
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	<u>Application to remainder of residents:</u> The care plans of every resident who has had a fall in the past 90 days will be audited and updated as needed by the IDT by 11/15/13. The individual care plans of all residents admitted in the last 4 months who are still residents will be audited by the MDS Nurse and SSD by 11/15/13 to ensure any items triggered on the MDS are care planned as needed.	11/15/13 11/15/13

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F 279	Continued From page 5 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to revise and implement care plans for 3 of 14 residents (6, 8, and 9). For Resident 6 and Resident 8, the facility did not revise the care plan after falls with new interventions. For Resident 9, the facility did not implement a care plan after the resident expressed suicidal ideation. Findings: 1. Resident 6's clinical record was reviewed on 10/24/13 at 8:05 a.m. It indicated witnessed falls on 5/25/13 at 5:30 p.m. and 10/18/13 at 7:40 p.m. There were nurse's notes on both days relating to the falls, as well as Post Fall Assessments and IDT notes. A review of the fall care plans dated 3/2/12 indicated no new revisions after the falls. During an interview on 10/24/13 at 12:25 p.m., licensed nurse B stated they already had everything on the care plans. "We add what happened, but we don't usually change the interventions." 2. Resident 8's clinical record was reviewed on 10/24/2013. The 9/26/2013 Interdisciplinary Team (IDT) Notes record indicated Resident 8 was found reclining on a chair and slid down from the chair. The 10/6/2013 IDT Notes indicated a second fall when Resident 8 was found on the floor of the resident's bedroom. The 8/12/13 "At Risk for fall/injury" care plan problem was updated and indicated falls on 9/26/2013 and 10/6/2013. Prior to the fall on 9/26/2013, Resident 8's care plan indicated to	F 279	<u>System application:</u> The licensed staff were inserviced on 11/4/13 by the DON regarding the facility fall procedures and updating care plans as needed after falls or other events. The fall protocol will be reviewed by the IDT and administrator and updated if needed by 11/15/13. <u>Monitoring:</u> Compliance will be monitored quarterly through audits of falls by the medical records designee and audits after admission MDS by the MDS Coordinator and SSD. The SSD will complete a checklist whenever there is a yes response to the mood interview question about suicidal thoughts. Any issues identified will be addressed in the	11/4/13 11/15/13 ON-Going

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F 279	Continued From page 6 remind to use the call bell. No new interventions were added to the care plan after the falls on 9/26/13 and 10/6/13 except to keep reminding the resident to call for help. During an interview with licensed nurse F (LN F) on 10/24/2013 at 9:30 a.m., LN F stated the care plan was not updated due to Resident 8's ability to ambulate independently and the resident being a low risk for falls. 3. On 10/25/2013, Resident 9's clinical record was reviewed. The Resident Mood Interview of the 9/12/2013's initial Minimum Data Sheet (MDS, an assessment tool) indicated Resident 9 had thoughts of being better off dead or hurting self. Resident 9's 9/12/2013 MDS section V indicated the need to develop a Mood/Behavior care plan. During an interview on 10/25/2013 at 10:45 a.m., licensed nurse M (LN M), the MDS coordinator, stated the Mood/Behavior care plan had not been developed for Resident 9. LN M stated the charge nurse would initiate the care plan according to the "New Admission Checklist," and then the director of nursing (DON) or LN M would follow-up to verify any missed care plans based upon the initial MDS. LN M stated the triggers in section V of the initial MDS needed to be transcribed onto a care plan. The record review on 10/25/2013 about the facility's 7/7/2009 "Health Information/Record Manual" policy indicated the facility must develop a comprehensive plan of care for each resident based on the needs identified in the Resident Assessment Instrument, of which the MDS is one of the three basic components.	F 279	quarterly QA meetings as needed. Date: ON-GOING	

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F 279	Continued From page 7 A 10/25/13 review of the facility's 7/7/03 "Falls" policy indicated to start a care plan immmediately after each fall, and identify the fall, goals, and appproaches to provide care and to prevent future falls.	F 279		