STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555080	A. BUILDING _____ B. WING _____	04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRACY NURSING AND REHABILITATION CENTER	545 WEST BEVERLY PLACE TRACY, CA 95376

(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
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an Annual Recertification Survey. Representing the Department of Public Health: HFEN, 14362 HFEN, 22210 HFEN, 29750 The facility census was 51. The sample size was 13.	F 000	APRIL 2014 - Plan of Correction: Tracy Nursing and Rehabilitation Center submits this response and plan of correction as part of the requirements under State and Federal Laws. This plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employees, agents, officers, directors, and shareholders The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by governmental agencies or third parties. The plan of correction shall constitute this facility's credible allegation of compliance.	Accepted 5-6-14 aw
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	**F329, 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** Corrective action(s) for residents found to have been affected by this deficiency:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: NHA | (X6) DATE: 5/2/14

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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F 329	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to ensure: 1. Two of 13 sampled residents (1 and 6) had complete assessments of their use of antipsychotic medication. 2. One of 13 sampled residents (3) had a gradual dose reduction of a sleeping medication when she had no behaviors of the inability to sleep for greater than 1 year. These failures had the potential to expose residents to unnecessary antipsychotic medications. Findings: 1. Resident 1 was admitted to the facility on 5/8/13. Her diagnoses included dementia. Her clinical record was reviewed on 4/7/14. Physician Orders, dated 9/24/13, were reviewed. Resident 1 had an order for Risperdal (an antipsychotic medication) 0.25 milligrams (mg) twice a day for dementia with agitated features manifested by "verbal abuse, cursing at staff during care." Resident 1's Psychotropic Summary data from 9/24/13 through 4/1/14 was reviewed. There was incomplete documentation for all 7 months for the behaviors demonstrated by Resident 1. There was no documentation of monthly summaries for the months of September, October, and December 2013. There was no monthly summary for the month of February 2014.	F 329	1. The Psychotropic Summaries were re-initiated in March 2014. 2. The Licensed Nurse staff was in-serviced regarding the completion of the monthly Psychotropic Summaries. 3. A monthly Psychotropic Interdisciplinary Meeting was initiated to include the Director of Nursing Services, the Social Services Director and or the Activities Director and the designated Pharmacist Consultant. 4. The resident charts containing orders for psychotropic medications were reviewed and recommendations were made regarding gradual dose reduction(s), necessity of a physician risks vs. benefits statements, and or discontinuation of medications as appropriate. 5. The designated Physician(s) were contacted and the necessary documentation or changes were obtained and/or made. <u>Corrective action(s) for residents that may be affected by this deficiency:</u> 1. All resident charts with psychotropic medication(s) were audited for the presence of a psychotropic summary and brought current. 2. All resident charts which contain a psychotropic medication(s) order were audited for completeness of the medication order and indication for the medication order. 3. All resident charts which contain a psychotropic medication(s) order were reviewed and	4/30/14 4/30/14

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F 329	Continued From page 2 An interview was conducted with the Director of Nursing (DON) on 4/8/14 at 8 a.m. She stated the nursing staff should have been completing the Psychotropic Summary sheets on a monthly basis to provide a complete assessment of the residents behavior patterns. 2. Resident 3 was admitted to the facility on 1/12/12. Her diagnoses included chronic pain and depression. Her clinical record was reviewed on 4/8/14. Physician Orders, dated 2/22/13, were reviewed. Resident 3 had an order for Trazadone (an antidepressant used to treat inability to sleep) 25 mg every night. Resident 3's Psychotropic Summary sheets for February 2013 through February 2014 were reviewed. Documentation indicated she had no behavior of inability to sleep. Resident 3's clinical record contained a Note To Attending Physician/Prescriber from the facility consulting pharmacy, dated 3/17/14. Documentation within the recommendation included, "This resident has been on Trazadone 25 mg [every evening] since 2/22/13. Please evaluate the current dose and consider a gradual taper to ensure this resident is using the lowest possible effective/optimal dose." The physician/prescriber response to the request, dated 3/19/14, was "[continue] same dose." There was no documented evidence of a risk versus benefit statement indicating why a gradual dose reduction was contraindicated for Resident 3's use of the Trazadone.	F 329	recommendations were made regarding gradual dose reduction(s), risks vs. benefits statements, and or discontinuation of medications as appropriate. Measure(s) that will be put in place to ensure that this deficiency does not recur: 1. All residents who are prescribed a psychotropic medication will have a corresponding Psychotropic Summary initiated as the order is received. 2. All resident charts with psychotropic medication(s) prescriptions will be reviewed monthly at the Psychotropic Interdisciplinary Meeting for appropriateness and necessary recommendations as well as necessity for physician documentation of risks vs. benefits statements. 3. All resident charts with psychotropic medication(s) prescriptions will be reviewed monthly at the Psychotropic Interdisciplinary Meeting for accurate completion of the Psychotropic Summary and necessity for changes. 4. All resident charts with psychotropic medications will also be reviewed at the initial and quarterly care conferences.	4/30/14

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F 329	Continued From page 3 An interview was conducted with the DON on 4/8/14 at 3 p.m. She acknowledged Resident 3 had been on the Trazadone for greater than one year with no behavior of inability to sleep. She acknowledged there was no documentation as to why a trial dose reduction was contraindicated. 3. Resident 6 was re-admitted to the facility on 3/18/14 with diagnoses including psychosis. Resident 6 had a physician's order, dated 3/18/14, for Risperdal 0.25 mg at bedtime for psychosis manifested by hitting. Further review of Resident 6's clinical record revealed that her Risperdal had been discontinued on 5/9/13 then restarted on 8/4/13. An interview was conducted with Licensed Nurse (LN) 1 on 4/9/14 at 11:25 a.m. She was asked about the monitoring of behavior episodes of residents prescribed medication to modify behaviors. LN 1 stated resident behavior episodes were documented on their monthly Medication Administration Record (MAR) every shift. When asked about a document titled "Psychotropic Summary," LN 1 explained the behavior monitoring information recorded on the MAR was totaled at the end of each month and transcribed onto the Psychotropic Summary sheet. LN 1 stated the Psychotropic Summary provided monthly behavioral data for each shift at a glance. There was no documentation of monthly summaries in Resident 6's clinical record for the months of August, September, October, and November 2013 and January and March 2014, a total of six months. An interview was conducted with the DON on	F 329	Measure(s) that will be implemented to monitor continued effectiveness of the corrective action(s) taken to ensure that this deficiency has been corrected and will not recur: 1. Medical Records will conduct an as needed daily audit as psychotropic medications are prescribed or changed for presence of a corresponding Psychotropic Summary form. 2. Medical Records will conduct a monthly audit for completeness of the monthly Psychotropic Summary. 3. Medical Records will conduct a monthly audit for the presence of documentation detailing the findings of the Psychotropic Interdisciplinary Team meeting.	4/30/14

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F 329	Continued From page 4 4/9/14 at 12:45 p.m. The DON stated if a Psychotropic Summary was not completed, the Interdisciplinary Team (composed of a Physician, Pharmacist, and Nursing) would have to review the MAR for monthly behavioral data. She stated, "[Psychotropic Summary] wasn't being done consistently."	F 329		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and facility document review, the facility did not meet the required 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Findings: On 4/9/14 at 8:30 a.m., seven 3-person bedrooms (1, 3, 5, 6, 8,10, and 11) were observed to be uncluttered with sufficient space for the personal effects of residents. There was ample room for entrance, egress, and maneuvering of equipment in and out of the room and to the bathroom. There were no apparent space issues for the delivery of care to the residents in these rooms. A review of facility records was made. The following variances were noted from the required 80 minimum square (sq.) feet (ft.) per resident in	F 458	Rooms 1,3,5,6,8,10 and 11 are kept with sufficient space for personal effects of residents but uncluttered enough for ingress and egress. There is also enough room for maneuvering around the room in matters of personal care. Residents in rooms 1,3,5,6,8,10 and 11 may have the potential to be affected by the deficient practice. The nursing staff will continue to keep rooms 1,3,5,6,8,10 and 11 with sufficient space for personal effects of residents and uncluttered enough for ingress and egress. The nursing staff will also maintain enough room to maneuver around the room in matters of personal care.	

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F 458	Continued From page 5 these 3-person bedrooms (required total 240 sq. ft.): 1. Room 1 75.2 sq. ft. per resident 2. Room 3 74.8 sq. ft. per resident 3. Room 5 73.5 sq. ft. per resident 4. Room 6 76.8 sq. ft. per resident 5. Room 8 76.1 sq. ft. per resident 6. Room 10 79.9 sq. ft. per resident 7. Room 11 75.6 sq. ft. per resident During Group Interview on 4/8/14 at 10 a.m., there were no complaints voiced regarding the size of resident rooms. On 4/9/14 at 9:30 a.m. interviews were conducted with 5 residents residing in the above listed rooms. None of the 5 residents voiced concern over their personal space. On 4/9/14 at 10 a.m. an interview was conducted with the Licensed Nurse providing care to the residents in the above listed rooms. She indicated there was no problem when they moved about or gave patient care in the rooms. The Department recommends to continue the room waver.	F 458	The other rooms meet the 80 sq. ft. per resident standard. The room sizes will remain the same except for rooms 1,3,5,6,8,10 and 11. The Director of Staff Development will inform the nursing staff during orientation, annually and during as needed inservice to maintain sufficient space to the rooms that did not meet the 80 sq. ft. per resident room standard for multiple residents. The Director of Staff Development will emphasize the need for sufficient space for personal effects of residents but uncluttered enough for ingress and egress. The need to provide enough room for maneuvering around the room in matters of personal care will also be emphasized.	
F 516 SS=D	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 516		

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F 516	Continued From page 6 except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safeguard clinical records against unauthorized use when the medical records office was found to be unlocked and unattended. This practice had the potential for unauthorized persons to have access to residents medical record information. Findings: On 4/10/14 at 9:05 a.m. the Medical Records office was found unlocked and unattended by medical records staff for a period of approximately 20 minutes. Medical records cabinets were found unlocked and accessible. Files of medical records were on the desk in medical records. When the Medical Records staff returned to the office, at 9:20 a.m., she stated it was her practice to close the door when she left, but it was not her practice to lock the door during business hours. She acknowledged this practice had the potential for unauthorized persons to have access to residents medical record information.	F 516	The Director of Staff Development/Designee will perform weekly rounds on various shifts to monitor compliance. The Safety Committee Chair will present a written report to the monthly QA&A Committee Meeting to ensure that corrective actions are being followed. 1. The door lock to the medical records office were changed on April 11th so that the door does not unlock even after the key is used for entry 2. The residents in the facility may have the potential to be affected by the deficient practice. The Medical Records staff will close And check the Medical Records Office door when she exit the Medical Record's office. 3. The Administrator inserviced on (date) the medical records department Staff about making sure that the door to the medical records office stays closed and locked. 4. The Administrator will perform a monthly check of the Medical Records' office door to assure that it is closed and locked. The Administrator will report to the monthly QA&A Committee the results of the monthly checks to ensure compliance.	4/30/14