California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000104	A. BUILDING _____ B. WING _____	C 08/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIENNA NURSING AND REHABILITATION CEN	800 SO. HAM LANE LODI, CA 95242

(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) COMPLETE DATE
A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of Complaint #CA00135373 Representing the Department of Public Health: HFEN, 1934 Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility.	A 000	This plan of correction was prepared in compliance with federal and state regulations, and is not intended to be an admission of the allegations contained herein. This plan of correction constitutes the facility's credible allegation of compliance.	
A 176	T22 DIV5 CH3 ART3-72313(a)(1) Nursing Service--Administration of Medication (a) Medications and treatments shall be administered as follows: (1) No medication or treatment shall be administered except on the order of a person lawfully authorized to give such order. This Statute is not met as evidenced by: Based on staff interview and review of Patient A's clinical record and other documents, the facility failed to get a physician's order to treat Patient A's abdominal wound prior to treating the wound. The treatment used on Patient A's abdominal wound was started on 12/15/07 and a telephone physician's order for the same treatment was written on 12/17/07 (2 days later). Findings: On 8/11/1 at 5:30 p.m., a copy of Patient A's	A 176	**A 176** a) Patient A was discharged from our facility on 12/18/2007 (3 years and 287 days prior to Vienna was notified that a deficient practice had occurred). Therefore, no corrective action can be made for this patient. b) All residents have the potential to be affected but no other resident has been identified through our current ongoing process during the past 1,381 days. c) The facilities system, policy and procedures for medication and treatment administration have been revised since December 2007. Several in-services have been provided to licensed nurses during that time period and a follow-up in-service will be provided on 10/27/11 to all licensed nurses regarding the facilities system on transcription of physician orders as well as the policy and procedure for medication and treatment administration.	

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A 176	Continued From page 1 clinical record was reviewed. Patient A had been transferred to the skilled nursing facility (SNF) from the general acute care hospital (GACH) on 12/14/07. GACH documentation showed that Patient A underwent abdominal surgery on 11/29/07 and on day 4 postoperatively she was noted to have purulent (pus) drainage from her wound. Documentation indicated that the staples were removed from the wound and, "her wound was opened." Further documentation read that the wound was not deep, but very long and that wet to damp dressing changes would have to continue until the wound healed. Patient A was admitted to the SNF on 12/14/07 at approximately 2 p.m. A review of Patient A's transcribed "Physician's Orders" sheet did not show a treatment order for Patient A's abdominal wound. A review of Patient A's treatment sheet showed a hand written order (initiated on 12/15/07) that read, "Cleanse wound with wound cleanser, pack gently with Carrasyn wound gel and iodoform (sterile gauze packing) BID (twice a day)." Further review showed that the treatment was only performed once on 12/15/07 and once on 12/16/07, instead of twice a day as documented on the treatment sheet. On 12/17/07 at 3 p.m. a physicians' telephone order read for the same treatment that had been initiated on 12/15/07 (2 days earlier). A complete review of the clinical record did not show evidence of a 12/15/07 initial physician's order for the treatment. On 8/12/11 at 12:30 p.m., Patient A's clinical record was reviewed in the presence of the current Director of Nurses (DON) and the Quality Assurance Nurse (QAN). They were unable to find an order that allowed the nurse to begin the treatment on 12/15/07 and both the DON and QAN concurred that there was no written order	A 176	d) A Quality Assurance position was added to our staff in 2008 and that position is responsible to ensure that identified residents with skin integrity impairment have treatment orders, a plan of care in place and has been implemented as ordered. The Medical Records Director or designee will continue their routine of weekly and monthly audits. Results of those audits will be provided to the Director of Nurses and the Administrator. A copy of the findings and necessary plans of action will be reported to the QA committee quarterly to ensure compliance. e) Date corrective action will be completed: 10/27/11	

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A 176	Continued From page 2 for the treatment and if there had been one, the treatment was not administered as written.	A 176		
A 177	T22 DIV5 CH3 ART3-72313(a)(2) Nursing Service--Administration of Medication (a) Medications and treatments shall be administered as follows. (2) Medications and treatments shall be administered as prescribed. This Statute is not met as evidenced by: Based on staff interview and review of Patient A's clinical record, and other documents, the facility failed to administer the drug Loperamide (anti-diarrheal medicine) to Patient A for her loose stools as prescribed per the physicians' order Findings: On 8/11/1 at 5:30 p.m., a copy of Patient A's clinical record was reviewed. Patient A had been transferred to the skilled nursing facility (SNF) from the hospital on 12/14/07. The hospital record showed that she had a history of abdominal pain, nausea and subsequent weight loss. In the hospital Patient A had undergone bowel surgery and was discovered to have cancer of the bowel. Hospital documentation also showed that Patient A experienced, "multiple bouts of diarrhea" and due to her decreased appetite received parenteral nutrition (feeding a person intravenously) throughout the	A 177	**A 177** a) The patient was discharged from our facility 1,381 days ago (3 years and 287 days ago) so we are unable to correct the deficient practice for that patient. b) All residents have the potential to be affected but no other resident has been identified through our current ongoing process during the past 1,381. c) Several in-services regarding the policy and procedures regarding medication and treatment administration have been provided to the licensed nursing staff since December 2007. A follow-up in-service will be conducted on 10/27/11 regarding medication and treatment administration P&P's as well as implementation and carrying out physician's orders. d) The RN Supervisors, QA nurse and MDS coordinators will ensure that the plan of care is implemented; that medication and treatment orders are administered to residents according to the prescribed physician orders during their routine chart review in conjunction with resident's scheduled PPS and/or OBRA assessments.	

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A 177	Continued From page 3	A 177		

hospitalization. Documentation showed that upon discharge to the SNF, Patient A was, "able to tolerate food with no difficulty."

Patient A was admitted to the SNF on 12/14/07 at approximately 2 p.m. A review of Patient A's, "Physician's Orders" sheet, showed a 12/14/07 transcribed order for Loperamide 2mg, 1 tablet after each loose stool with the total day's dose of the medication not to exceed 16mg (total 8 tablets) per day. A review of the, "Activities of Daily Living Flow Sheet" (ADL) and the medication administration sheet (MAR) for all three shifts showed the number of Patient A's loose stools and treatment on:

12/14/07 The ADL sheet read that Patient A had 3 loose stools on the evening shift (p.m.) and 3 loose stools on the night shift (noc). A review of the MAR showed that she received 1 dose of Loperamide on the p.m. shift and 2 doses on noc's. Review of the documented nurse's notes read that Patient A had arrived at the facility at approximately 2 p.m. and experienced a total of 4 loose stools since her arrival and throughout the noc shift.

12/15/07 The ADL sheet read that Patient A had 5 loose stools on the day (a.m.) shift, 2 loose stools on p.m.'s and 3 on nocs. The MAR showed that she received 2 doses of the medication on the a.m. shift, 1 dose on p.m.'s and 1 dose on the noc shift. Review of the nursing documentation read that Patient A had a total of 9 loose stools in that 24 hour period.

12/16/07 The ADL sheet read that in the a.m shift Patient A had 4 loose stools, 2 on p.m 's and 2 on nocs. The MAR showed that she received 3 doses on the a.m. shift, 1 on p.m.'s and none on

Medical Records Director will continue their routine weekly and monthly audit. The Pharmacy Consultant will continue to review each resident's record on a monthly basis. Findings of audit and record reviews will be reported to the Director of Nurses and Administrator. A copy of the findings and necessary plans of action will be reported to the QA committee on a quarterly basis.

e) Date corrective action will be completed: 10/27/11

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A 177	Continued From page 4 nocs. Review of the nursing documentation read that Pateint A had a total of 8 loose stools in that 24 hour period 12/17/07 The ADL sheet read that Patient A had 4 loose stools in the a.m., 3 stools on the p.m. shift and 4 on the noc shift. The MAR showed that she received received 2 doses on the a.m. shift, 2 on the p.m. and 2 on the noc shift. There was no nursing documentation for the a.m. shift, the p.m. shift indicated that she had 3 loose stools and noc shift indicated there were 5 loose stools on that shift. On 12/18/07 at 7:30 a.m., a physician's telephone order read for Patient A to be transported to the emergency department for evaluation. Review of the nurse's notes at 7:30 a.m., read that Patient A had become very weak and had experienced 11 loose stools in the past 18 hours . Nursing documentation on the transfer sheet indicated that Patient A was admitted to the SNF 12/14/07 and has had liquid stools, not eating and getting very weak. On 8/15/11 at 11:10 a.m., an interview was conducted with the RAI (Resident Assessment Instrument) Nurse who was the Director of Nurses at the time Patient A was in the SNF. Patient A's clinical record was reviewed along with the treatment for her diarrhea. The RAI Nurse stated that she did not remember this case; however, after reviewing the record it was clear that there was not enough Loperamide given to Patient A for her loose stools to evaluate whether the medication was working.	A 177		
A 815	T22 DIV5 CH3 ART5-72523(c)(2)(D) Patient Care Policies and Procedures	A 815		

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A 815	Continued From page 5 (c) Each facility shall establish and implement policies and procedures, including but not limited to: (2) Nursing services policies and procedures which include: (D) Notification of physician regarding sudden or marked adverse change in a patient's condition. This Statute is not met as evidenced by: Based on staff interview and review of Patient A's clinical record, facility policy and procedure (P&P) and other documents, the facility failed to follow their P&P when Patient A's physician would not commit to coming in to see her after the facility notified him that family was requesting him to see her due to her decreased appetite and severe diarrhea. Patient A's family asked for her physician to come in and upon notification, he did not state whether he would come in and the facility did not escalate the concerns about Patient A's clinical status to the Medical Director. Findings: On 8/11/1 at 5:30 p.m., a copy of Patient A's clinical record was reviewed. Patient A had been transferred to the skilled nursing facility (SNF) from the hospital on 12/14/07. The hospital record showed that she had a history of abdominal pain, nausea and subsequent weight loss. Hospital documentation also showed that Patient A experienced, "multiple bouts of diarrhea" and due to her decreased appetite received parenteral nutrition (feeding a person intravenously) throughout the hospitalization. Documentation showed that upon discharge to the SNF, Patient A was, "able to tolerate food with no difficulty."	A 815	**A815** a) Patient A was discharged on 12/18/07, 1,381 days ago so we are unable to implement corrective action for this resident at this time. b) All residents have the potential to be affected but no other resident has been identified through our current ongoing process during the past 1,381 days. c) Several in-services have been provided to Licensed Nurses regarding "change of condition notification". A follow-up in-service with the Licensed Nurses will be provided on 10/27/11 to ensure ongoing compliance. d) The RN Supervisor reports any changes of condition to the IDT during daily stand-up meetings. The IDT reviews resident records identified with change of condition to ensure necessary notification to physician and responsible party were made and the plan of care is in place and implemented. The DON or designee, QA Nurse, RN Supervisors and the MDS Coordinators will monitor by checking the 24 hour reports at the beginning of the shift to ensure compliance. e) Date corrective action will be completed: 10/27/11	

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A 815	Continued From page 6	A 815		

A review of Patient A's, "Activities of Daily Living Flow Sheet" (ADL), showed that she was experiencing several bouts of loose stool since her admission on 12/14/07. In addition, Patient A's appetite was decreased with an intake of less than 50% for breakfast, lunch and dinner for the dates 12/14/07 to 12/18/07. Nursing documentation on the transfer sheet indicated that Patient A was admitted to the SNF 12/14/07 and has had liquid stools, not eating and getting very weak.

A nurse's note dated 12/17/07 at 3 p.m. read that Patient A's family had requested that the physician come in to evaluate her. Per the nurse's notes, the physician was, "very noncommittal" (about coming in) The documentation did not describe Patient A's bouts of diarrhea and decreased oral intake. There was no follow-up call to the doctor and the next nursing note was dated 12/18/07 at 7:30 a.m. (12 hours later) that Patient A had become very weak and had experienced 11 loose stools in the last 18 hours. There was no documentation of Patient A ' s change of condition prior to this note, or that Patient A's physician was re-contacted due to her now weak condition.

On 12/18/07 at 7:30 a.m., a physician's telephone order read for Patient A to be transported to the emergency department for evaluation. Nursing documentation on the transfer sheet indicated that Patient A was admitted to the SNF 12/14/07 and has had liquid stools, not eating and getting very weak.

On 8/15/11 at 11:10 a.m., an interview was conducted with the RAI (Resident Assessment Instrument) Nurse who was the Director of Nurses at the time Patient A was in the SNF The