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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. BUILDING ____ B. WING ____	C 10/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB - SMITH RANCH	1550 SILVEIRA PARKWAY SAN RAFAEL, CA 94903

(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 represents the findings of the California Department of Public Health during a recertification survey. Representing the California Department of Public Health: Health Facilities Evaluator Nurses 32961, 27533, and 34269. There were 10 sampled residents and 3 random residents. The census on the date of entry, 10/13/14, was 38 with no bed holds. There was one Entity Reported Incident (ERI) that was investigated during the survey: CA00400350. No deficiencies were issued for the ERI.	F 000	*This plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS ID prefix tag F 281** Facility staff "D" did respectfully disagree with evaluator however we are writing plan of correction so indicated below.	Completion Date 11/16/14
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that staff administered medication per physician's order for one of the 29 observed medications. This failure resulted in one random resident (Random Resident 11) receiving a decrease dose of prednisone (A medication that decreased inflammation, source from online.lexi.com) and had the potential to cause harm to the resident. Findings:	F 281	**1. List of corrective actions for resident affected by the issue:** Resident 11 has been discharged from the facility. As per policy and procedure titled "Medication Errors", the physician and resident 11 were notified of the incident by Director of Nursing Services. A comprehensive assessment was performed by the physician and no adverse outcome was noted. The physician assured resident 11 of no adverse outcome. Resident 11 requested for her prednisone to be reduced and tapered at the time of the physician's assessment. The resident 11 was	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ritu Jain RN
TITLE: Director of Nursing Services
(X6) DATE: 12/04/14

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.

Revised POC accepted 12/4/14.
facility notified 12/3 writing and
signature

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F 281	Continued From page 1 During a concurrent observation and interview on 10/14/14, at 8:50 a.m., Licensed Staff D was observed preparing and administering prednisone 1 milligram (mg) (one tablet) and prednisone 10 mg (one tablet) to Random Resident 11. Licensed Staff D stated that she pulled one tablet from a prednisone bubble card of a 1 mg per tablet and one tablet from another prednisone bubble card of a 10 mg per tablet. Licensed Staff D confirmed that the resident received total of 11 mg of prednisone. Random Resident 11's physician order, dated 9/12/14, indicated "PREDNISONE 13MG (ONE 10 MG TABLET WITH THREE 1MG TABLETS = 13MG TOTAL) PO (BY MOUTH) DAILY FOR POLYMYALGIA RHEUMATICA (Inflammation of joints including shoulder and hip joints that caused pain and stiffness at the upper arms, neck, lower back and thighs, source from rheumatology.org)." The facility policy titled "6.0 General Dose Preparation and Medication Administration," dated 1/1/13, indicated "...Facility staff should verify that the medication name and dose are correct..." The facility policy titled "Medication Errors," dated 1/8/13, indicated "Medication Error...The observed preparation or administration of drugs or biologicals that are not in accordance with: a. Physician's Orders..."	F 281	monitored for adverse outcomes by Licensed staff (LVN/RN)related under dosing for 72 hours. As per policy and procedure titled "Medication Errors", the factual information on error, physician notification, outcomes were provided in patient's medical record. **2. Identification of others at Risk:** The residents under care of Licensed staff 'D' have a potential to be affected. The pharmacist did a drug regimen review on all patients under care of Licensed staff 'D' and performs a drug regimen review three times a month for all patients in building. In case of corrective action needed, the licensed staff 'D' will be suspended from floor and will have to go through orientation with staff development coordinator on correct medication administration and will be followed by staff development coordinator until demonstrate correct procedure. As per policy and procedure titled "Medication Errors" the factual information on error will be added to patient chart, physician, resident will be notified by Licensed staff (LVN/RN) and patient will be monitored for adverse outcomes by Licensed staff (LVN/RN) as needed. **3. System Changes:**	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive	F 328		

12/4/14 Revised POC accepted
facility notified.

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F 328	Continued From page 2 proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed ensure that staff followed its policy and procedure for subcutaneous injection for one of 10 sampled residents (Resident 9). This failure had the potential for altering the effectiveness of the medication. Findings: During an observation on 10/14/14, at 12:12 p.m., Licensed Staff E administered insulin to Resident 9 using one hand to pinch Resident 9's abdominal (stomach area) skin and another hand to insert the needle in a transverse direction. Licensed Staff E inserted the needle superficially just underneath the skin and injected the insulin. During an interview on 10/14/14, at 12:25 p.m., Licensed Staff E stated that she inserted the needle like intradermal injection technique (insert needle 5 to 15 degree angle, source from atitesting.com). She stated that today, she had over analyzed the procedure and thought the subcutaneous injection technique she used was more superficial and just underneath the skin.	F 328	Licensed staff will be in-serviced by the staff development coordinator on the policy and procedure titled "General Dose Preparation and Medication Administration". **4. Monitoring:** Staff development coordinator or designee will conduct medication administration review of licensed staff on a monthly basis for 3 months and then yearly after. All new hires competencies will be conducted within 90 days and yearly there after. Concerns will be brought forward by the DNS to the Performance Improvement Committee on the monthly basis. The Executive Director or Designee is responsible for overall compliance. **483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS** **1. List of corrective actions for the resident affected by the issue:** Resident 9 has been discharged from the facility. Upon notification from state surveyor, the blood sugar values were reviewed with state surveyor by DNS for meals after and no spike in blood sugar noted.	Completion Date 11/16/14

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F 328	Continued From page 3 She also stated that she should have inserted the needle deeper with an approximate 45 degree angle. During an interview on 10/16/14, at 10:45 a.m., Administrative Staff C stated that using intradermal injection technique for subcutaneous injection was not acceptable because the injection technique would affect the medication absorption and could change the effectiveness of the medication. The facility policy and procedure titled "Subcutaneous Injection," dated 8/31/12, indicated "...Hold the syringe like a pencil with the bevel up, and insert needle at a 45 - 90 (45 degree to 90 degree) angle to the skin surface..."	F 328	**2. Identification of others at Risk:** The residents with an order for subcutaneous injection under care by licensed staff 'E' have the potential to be affected. Staff development coordinator performed a test on licensed staff 'E' on administration of subcutaneous injection. Licensed staff 'E' showed proper administration of subcutaneous injection. Licensed staff 'E' was in-serviced by the staff development coordinator on manikin on correct administration of subcutaneous injection with return demonstration x 3 days. If corrective action is needed, the licensed staff 'E' will be suspended from floor and will have to go through orientation with staff development coordinator on all clinical skills part of new hire orientation with successful return demonstration. **3. System Changes:** Licensed staff will be in-serviced by staff development coordinator on the policy and procedure titled "subcutaneous injection". A return demonstration will be performed on each licensed to ensure proper technique. All new hires competencies will be conducted within 90 days and yearly there after.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		

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F 441	Continued From page 4 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that: 1) staff provided barrier protection for medical equipment used at bedside for one of 10 sampled residents (Resident 9); 2) staff used aseptic technique (a method used to prevent contamination) during blood glucose (sugar) monitoring procedure; and 3) staff performed hand hygiene between resident contact and preparing medications. These failures had the potential to cause spread of infection among the resident population which could lead to physical decline and possible death. Findings: 1) During an observation on 10/14/14, at 6:36 a.m., Licensed Staff F brought the medical equipment used for blood glucose monitoring:	F 441	**4. Monitoring:** The staff development coordinator will review competencies on a yearly basis on all licensed staff and all newly hired licensed staff will be conducted within 90 days and yearly there after. Concerns will be brought forward by the DNS to the Performance Improvement Committee on the monthly basis. The Executive Director or Designee is responsible for overall compliance. **483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** **1. List of corrective actions for the resident affected by the issue:** Resident 9, 12 and Resident 13 have been discharged from the facility. Vital signs for residents 9, 12 and 13 were reviewed by staff development coordinator for 72 hours. All residents remained afebrile and had no signs and symptoms of active infection. **2. Identification of others at Risk:** Residents under care by licensed staffs 'E', 'F' and 'G' have the potential to be affected.	Completion Date 11/16/14

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F 441	Continued From page 5 glucometer (a device used to measure blood sugar), lancet, and alcohol pads to Resident 9's bedside for blood glucose monitoring procedure. Licensed Staff F placed the medical equipment directly on the resident's bedside table with no barrier protection and continued with the procedure. During an observation on 10/14/14, at 11:40 a.m., Licensed Staff E brought the medical equipment used for blood glucose monitoring: glucometer, lancet, and alcohol pads to Resident 9's room. Licensed Staff E placed the equipment directly on the top of the blanket of an empty bed without a barrier protection. Licensed Staff E completed the procedure using the empty bed for working surface. During an interview on 10/15/14, at 3:45 p.m., Administrative Staff B stated that the blood glucose monitoring procedure included cleaning the bedside table surface with bleach wipe, placing a clean paper towel on the table, and placing the equipment on top of the paper towel. During an interview on 10/16/14, at 10:45 a.m., Administrative Staff C stated that placing the medical equipment directly on resident's bedside table without a barrier protection was not acceptable. She stated that resident's bedside table could have food or substance which could contaminate the equipment. Administrative Staff C also stated that placing the medical equipment directly on the top of the blanket of an empty bed was not acceptable. Administrative Staff C stated that the blanket could be contaminated and a new resident might admitted to the bed with the contaminated blanket. She stated she would have the staff to change the blanket.	F 441	Staff development coordinator performed a test on licensed staff 'E' and 'F' for blood glucose monitoring and proper infection control measures during procedure. The licensed staffs 'E' and 'F' were provided "One on One" in-service by staff development coordinator on manikin on correct technique on blood glucose monitoring and proper infection control technique during procedure with return demonstration x 3 days. If corrective action is needed, the licensed staff 'E' and 'F' will be suspended from floor and will have to go through orientation with staff development coordinator on all clinical skills part of new hire orientation with successful return demonstration. Staff development coordinator followed licensed staff "G" for proper hand hygiene with 3 different patients' vital check and medication administrations/preparation, for demonstration of proper hand hygiene/infection control. If corrective action will be needed, licensed staff "G" will receive further teaching and education until demonstrate proper technique. **3. System Changes:** Licensed staff will be in-serviced by the staff development coordinator on the	

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F 441	Continued From page 6 The facility policy and procedure titled "Blood Glucose Monitoring Using a [name of] Glucometer," dated 2/7/14, indicated "Patient Testing...Place cleaned machine on barrier on table/cart..." 2) During an observation on 10/14/14, at 6:36 a.m., Licensed Staff F performed blood glucose monitoring procedure for Resident 9. After she cleaned the puncture site with alcohol, she immediately used the first paper tissue hanging out from the tissue box on resident's bedside table to wipe the puncture site. Then she punctured the skin for a blood sample. During an interview on 10/14/14, at 7:15 a.m., Licensed Staff F stated that she used the paper tissue to dry the puncture site before she punctured the skin for blood sample to avoid mixing the blood with alcohol. She stated that she believed her mistake was to use the paper tissue to dry the puncture site. During an interview on 10/15/14, at 3:45 p.m., Administrative Staff B stated that the puncture site should be cleaned with alcohol and allowed air dry. She stated that using paper tissue to dry the puncture site was not acceptable because the puncture site could be contaminated by the paper tissue. The facility policy and procedure titled "Blood Glucose Monitoring Using a [name of] Glucometer," dated 2/7/14, indicated "Patient Testing...Using an alcohol pad, clean the puncture site and dry thoroughly after with a dry gauze pad..."	F 441	policy and procedure titled "Blood Glucose Monitoring Using a [name of] Glucometer". A return demonstration will be performed on each licensed to ensure proper technique while performing blood glucose monitoring. All new hires competencies will be conducted within 90 days and yearly there after. Staff will be in-serviced by staff development coordinator on facility policy and procedure titled "Hand Hygeine/Handwashing" and return demonstration will be performed. **3. Monitoring:** The Licensed staff after initial in-service on blood glucose monitoring/infection control technique will be monitored for 3 months on monthly basis by staff development coordinator by random observation. After 3 months, staff development coordinator will review competencies on blood glucose monitoring on a yearly basis on all licensed staff and all newly hired licensed staff will be conducted within 90 days and yearly there after. After initial in-service, staff development coordinator will review hand hygiene/hand washing with staff for 3 months on monthly basis by random observation then yearly after and as needed.	

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F 441	Continued From page 7 3) During an observation on 10/14/14, at 8:10 a.m., Licensed Staff G took vital signs including blood pressure for Random Resident 12. Licensed Staff G proceeded to prepare medications from the medication cart without first washing his hands or using a hand sanitizer. During an observation on 10/14/14, at 8:25 a.m., Licensed Staff G took vital signs including blood pressure for Random Resident 13. Licensed Staff G proceeded to prepare medications from the medication cart without first washing his hands or using a hand sanitizer. During an interview on 10/16/14, at 10:45 a.m., Administrative Staff C stated that omission of hand hygiene between taking vital signs and preparing medications was not acceptable because the omission of hand hygiene could cause contamination of the medication cards and the medication cart. The facility policy and procedure titled "Hand Hygiene/Handwashing," dated 8/31/11, indicated "Handwashing is the single most important procedure for preventing the spread of infection. If soap and water are not available and hands are not visibly soiled, an alcohol-based hand rub (ABHR) may be used for routine decontamination of hands in clinical situations...Hand hygiene is to be performed...Intermittently after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments..."	F 441	Concerns will be brought forward by the DNS to the Performance Improvement Committee on the monthly basis. The Executive Director or Designee is responsible for overall compliance.	