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

PRINTED: 04/20/2016
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
	555164	A. BUILDING _____ B. WING _____	C 02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR REHABILITATION & NURSING CENTER	900 NORTH CHURCH STREET LODI, CA 95240

PoC accepted 4/20/16 CO

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F 000	INITIAL COMMENTS The following represents findings of the California Department of Public Health during an abbreviated survey for the investigation of an entity reported incident #CA00452882. Representing the Department: HFEN, 32481. The inspection was limited to the specific event investigated and does not represent the findings of a full inspection of the facility.	F 000	This plan of correction constitutes the facility's written 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 the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483. **F246** **Immediate corrective action for those Residents affected by the deficient practice;** Resident 2 was moved to a different room on 2/21/2016.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, facility staff interview, and facility record review, the facility failed to accommodate two of two residents (R), R 1 and R 2 individual needs regarding roommate preference. This failure had the potential for causing undue stress to the residents. Findings: On 8/11/15 a visit was made to the facility to investigate an Entity Self Report (ERI) regarding an incident that occurred between R1 and R2.	F 246	**Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action to be taken;** All residents have the potential to be affected. **Facility measures and systemic changes to ensure the deficient practice does not recur;** The Director of Nurses (DON) and/or Director of Staff Development (DSD) in-serviced the Inter-Disciplinary Team (IDT) on 04/20/2016 regarding Accommodation of Needs. Room changes are discussed during stand up and during any review of resident incidents. Room changes will be tracked by Social Services and any issues or trends will be brought to the Quality Assurance and Assessment (QAA) meeting. **Facility plan to monitor corrective actions and sustain compliance; integrate Quality Assessment and Assurance (QAA) Process;** Social Service Director to bring trends regarding room change requests and room changes to QAA for discussion and resolution. **Completion Date: 04/20/2016**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tyson [signature] | TITLE: Administrator | (X6) DATE: 4-20-16

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 246	Continued From page 1 During a tour of the facility on 8/11/15 at 2:15 p.m., it was noted that R 1 and R 2 were roommates. R 2 was close to the window so she could keep her room dark and quiet, while R 1 was near the door. According to the 8/2/15 ERI, and follow up SBAR (Situation Background Assessment and Recommendation, a document completed by the facility when an incident occurs), received from the facility: "Room Mate (R 2) was standing at foot of the bed yelling at resident (R 1) for pulling the curtain and (R 2) is squeezing resident (R 1's) foot ... (R 2) was moved to another room right away...". Review of another document the facility sent to the Department regarding the incident was an 8/2/15 care plan for R 1. The care plan indicated that interventions to be implemented regarding the incident between R1 and R 2 included "Relocate roommate, (R 2)." Review of R 2's clinical record showed R 2 was admitted to the facility [redacted] She was ambulatory, and able to communicate needs. Review of R 1's clinical record indicated R 1 was admitted to the facility [redacted] dementia (changes in the mental status of some patients that effects, physical, behavioral of an individual causing change in their life style). R 1 was not able to communicate needs. [redacted]	F 246		

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	555184	A. BUILDING _____ B. WING _____	C 02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 246	Continued From page 2 [redacted]	F 246		

During an interview with Licensed Nurse (LN 1), on 8/12/15 at 9:20 a.m., LN 1 stated that R [redacted] distressing and would aggravate R 2. R 2 would often come to the nurses' station and ask the staff to do something about her roommate [redacted] stated she had written request to the Social Services Director (SCD) and to the Director of Nursing (DON) to have R 1 moved to another room to allow R 2 to rest better. On the night the episode occurred, when R 2 was observed squeezing R 1's feet, LN 1 stated she separated them and moved R 2 to another room. However, LN 1 stated that when she came back the next night shift, she found the two residents had been put back in the same room together. LN 1 stated she did not know why the residents had been put back together.

During an interview with LN 2 on 8/12/15 at 1:40 p.m., she confirmed that [redacted] bothered and aggravated R 2. LN 2 stated she had also left a note for the DON and social services, about a room change, but nothing had been done about moving the two residents.

During an interview with Certified Nurse Assistant 1 (CNA 1) on 8/13/15 at 8:40 a.m., she confirmed that R 1 [redacted] would aggravate R 2. CNA 1 stated she had observed R 2 squeezing R 1's feet and when CNA 1 asked R 2 what she was doing, R 1 responded that ["..You tell her to leave that alone"] in reference to R 1 holding the curtains. CNA 1 had reported this incident to LN 2. CNA 1 and LN 2 then had to separate R 2 from being in same room with R 1.

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F 246	Continued From page 3 During an interview with the SCD on 8/11/15 at 2:30 p.m., she confirmed that R 2 liked to keep to herself. [redacted] SCD agreed that she was aware of R 1 [redacted] and that R 2 had reacted by grabbing R 1's feet. During an interview with the Activity Director (AD) on 8/11/15 at 3:15 p.m., she confirmed that R 2 "Liked to be alone, [redacted] she likes it quiet". AD continued, " She may have been upset when her roommate was not quiet". Further, AD continued [redacted] During an interview with DON on 8/17/17 at 11:36 a.m., she stated that R1's family had requested a room change to "Give their family member a more sociable roommate." The DON confirmed R1 was still sharing a room with R 2 despite the family's request and the incident that occurred on 8/2/15.	F 246		