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

PRINTED: 11/18/2015
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
	056410	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITNEY OAKS CARE CENTER	3629 WALNUT AVENUE CARMICHAEL, CA 95609

Deb Hayes acceptable POC 1/14/16

(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 a Recertification survey. Representing the Department: HFEN #29917 / 1956 HFEN #29821 / 1946 HFEN #32481 / 2660 HFEN #36599 / 2904 HFEN #36586 / 3018	F 000	**PLAN OF CORRECTIONS** **"This plan of correction is prepared as part of the quality assurance process for the provider. This plan of correction and any attached documents are prepared with substantial reliance upon privileged peer review information and/or reports and as such are protected from discovery."** **"This plan of correction is prepared, submitted and/or executed solely because it is required by local, state and/or federal regulations, codes, and or guidelines. As this transmission is required by law, it is not a waiver of the provisions within applicable laws and regulations or any other codes, statutes or regulations."**	11-26-15
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on resident interview and document review, the Skilled Nursing Facility (SNF) failed to provide care with respect and dignity when call light responses were not timely for 1 of 24 sampled residents (Resident 18) and 13 confidential random residents. This failure negatively affected residents in a variety of ways including, but not limited to, loss of bladder control resulting in incidents of self-soiling, lying in soiled briefs for uncomfortably long time periods, and dignity-related issues. Findings: 1.Resident 18 was admitted to the SNF for	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE RN | (X6) DATE 1-14-16

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 241	Continued From page 1 rehabilitation services following hip surgery. On 11/2/15, a physician order noted, " Resident is capable of understanding rights, responsibilities, and informed consent. " During an interview conducted during the initial facility tour on 11/3/15 at 7:57 a.m., Resident 18 stated the previous night had been "the worst night of [her] life." The resident indicated she rang her call light at 12 a.m., 11/3/15 but it was not answered until 1:30 a.m., 11/3/15. Resident 18 stated she normally maintained bladder control but on this night "wet the bed" twice because "[she] could not hold it." She expressed feeling that staff members had neglected to answer her light in timely fashion which caused her to wet the bed, a situation which she described as "undignified" and which led her to cry. 2. During the initial facility tour at 8:18 a.m.,11/3/15, Confidential Resident C expressed concern that because her roommate's call light was not always answered in timely fashion, the roommate endured lying in a wet brief for extended periods of time. In the facility's 11/3/15 "Roster/Sample Matrix," a tool describing each resident, Confidential Resident C was not noted to have cognitive impairment. 3. Confidential Resident D was admitted to the facility with several chronic disease processes. Review of her medical record indicated a score of 15 of 15 on the Brief Interview for Mental Status (BIMS) exam, an evaluation of mental processes including perception, memory, judgment, and reasoning.	F 241	F 241 Resident 18, 5 day minimum data assessment (MDS) dated 11/9/15 and Activity of daily living (ADL) documentation indicated that she remained continent at the facility and into her discharge on 11/10/15. For all other residents listed as confidential/current/future residents, the facility implemented the Patient Advocate Representative program (PAR) as a tool to identify affected resident and implement corrective actions. Each of the department heads is assigned a few rooms (6-8 residents) to visit at least twice a week and inquire about any concerns to include call lights. The department heads will report the resident feedback at the daily department head meeting and	11-26-15

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F 241	Continued From page 2 During the initial facility tour at 8:42 a.m., 11/3/15, Confidential Resident D stated that when she was placed on a commode and left by staff members, a call light was not always left within her reach. She stated it took up to 30 minutes for her call light to be answered. 4. During the initial facility tour at 8:42 a.m., 11/3/15, Confidential Resident E estimated it took "half an hour" to respond to her call light "if they come at all." Review of her medical record indicated a BIMS score of 15. 5. During the initial facility tour at 8:59 a.m., 11/3/15, Confidential Resident F stated call lights took "a long time to get answered." She added that call light response issues existed at "all times of the day." Review of Confidential Resident F's clinical record indicated a BIMS score of 14. 6. During the initial facility tour at 9:56 a.m., 11/3/15, Confidential Resident G related that call lights took "much too long" to be answered "almost every time you put on the light." She added that when staff did not respond to her call light in timely fashion, she would involuntarily urinate in her bed. Confidential Resident G was not noted to have cognitive impairment according to the "Roster/Sample Matrix." 7. During an interview at 11:45 a.m., 11/4/15, a family member of Confidential Resident H stated,	F 241	the DON/DSD will follow up accordingly. For all residents, to include the confidential residents that have been affected by this deficient practice, the Director of staff development (DSD) in serviced staff on 11/25/15 to ensure to answer call lights are responded to in a timely manner. The facility policy indicates that call lights will be answered in a timely manner. A brief resident council meeting attended by 10 random residents held on 11/25/15 lead by the resident council president, reported back to the DON indicated that call light are responded to in a timely manner. He indicated that the residents stated that once they turn on the light, the staff will come into the room in a timely fashion and meet their needs.	11-26-15

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F 241	Continued From page 3 "I showed up one night after 11p.m., and found [the resident] had called [nursing staff] and no one had answered her. She was wet from the neck down. I could wring out urine from her linen. With State [surveyors] here, all is well. Call lights are answered. But after 11 p.m., it is totally different. [Resident H] calls and no one comes to answer [the call light]." The family member stated she had brought the problem to the attention of the resident's Certified Nurse Assistants (CNAs) as well as a member of facility leadership. However, she added that she would not want staff to know she complained to surveyors for fear of what would happen to [the resident's] care. 8. In a 9:35 a.m., 11/6/15 interview, Confidential Resident O expressed concern that her roommate was left on the commode "for up to 45 minutes. She [urinates] really fast. There's no reason they can't stand there and wait for her." Review of Confidential Resident F's clinical record indicated a BIMS score of 15. Resident Council minutes from 7/15 - 10/15 were reviewed with permission from the group's resident chairman. Minutes from the 7/7/15 Resident Council meeting stated, "Old Business..Noc [night] shift call lights take 30 minutes - 1 hour (100, 200, 300 halls) - (improved)..." Minutes were signed by the Resident Council Chairman and the Activities Supervisor and stamped as having been reviewed by the Administrator on 7/10/15.	F 241	Each shift supervisor will check on call lights and ensure the staff responds to resident needs in a timely fashion. The Director of Staff Development (DSD) and Director of Nursing (DON) will do random visits with resident(sample of 10-15 residents) weekly times 4 weeks and monthly thereafter to inquire about call lights. Any concerns identified will be addressed/in serviced accordingly. The Activity Director (AD) will continue to address the timeliness of answering call lights at each of the monthly Resident council meeting and have the DSD, DON attend as needed. Any concerns identified at this meeting will ne brought forward to the DON or designee for follow up.	11-26-15

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F 241	Continued From page 4 8/4/15 meeting minutes, however, reflected, "200 Hall, 300 Hall and 500 Hall - Day shift & p.m. shift - Sometimes no CNAs avail [available] to help residents to go to the Rest Room." Minutes were signed by the Chairman and Activities Supervisor and stamped as reviewed by the Administrator on 8/7/15. Review of "Old Business" during the 9/11/15 Resident Council included, "Call Lights from Day shift and PM shift (200, 300, 500 Halls) - Sometimes CNAs ...not avail to help residents for Toileting. Still ongoing." "New Business" included, "Suggestions from Absentee participants...More help to answer call lights, especially noc shift...." Nursing department's response to the concern read, "DSD [Director of Staff Development] and DON [Director of Nursing] will attend...next resident council meeting to discuss resolutions and will inservice staff to answer call lights on timely manners [sic]." Minutes were signed by the Chairman and Activities Supervisor and stamped as reviewed by the Administrator on 9/15/15. The 10/6/15 "Resident Council Minutes Report - Old Business" reflected, "Call Lights from Day shift - Improved. PM shift/NOC Shift (100, 200, 300, 500) Halls - Call lights takes [sic] 30 - 45 minutes...." "New Business" read, "DON and DSD invited by President of the resident council to discuss call lights...DSD will be here this coming Friday 10-16-15 and meet Nurses and CNAs to discuss PM and noc shift call lights and will follow up with resident [sic] after that date." During the survey Group Interview, begun at 10:45 a.m., 11/4/15, Confidential Residents expressed the following continuing concerns	F 241	The AD will report any non-compliance to the Quality Assurance Committee for recommendations.	11-26-15

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F 241	Continued From page 5 regarding staff response to call lights: 7 of 8 Confidential Residents indicated that CNAs did not realize the urgency of answering call lights in timely fashion; Confidential Resident D stated lights were not answered quickly enough to get residents to commodes or to the bathroom in time to prevent incidents of soiling, Residents had to lie in wet briefs for longer than they felt acceptable, Call lights "frequently" not responded to for over 30 minutes, with Confidential Residents D, J and M reporting usual response times of 30 - 45 minutes, Confidential Resident J stated call lights turned on during shift changes were responded to by staff who turned them off, indicated they would return "after rounds" or other tasks, then did not return, Confidential Resident J also indicated night shift call lights remained unanswered sufficiently long enough that activating residents fell back asleep; responding staff then turned off lights without inquiring about resident needs, Staff sometimes "rude" to or "short" with residents when answering call lights, Fear of retribution if call light response concerns were voiced to staff. Review of the facility's 9/03 "Answering the Call Light" policy reflected, "Answer the resident's call light as soon as possible...Turn off the signal light. Identify yourself and call the resident by his/her name...Listen to the resident's request. Do what the resident asks of you, if permitted...." In an 11:05 a.m., 11/6/15 interview, the facility Administrator acknowledged that call light response time had been a resident issue, but noted the situation had been "improved."	F 241		11-26-15

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F 247 SS=E	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to give notice prior to room change for 6 of 24 sampled residents, (Residents 1, 4, 5, 11, 12 and 15). This failure caused emotional distress to these residents. Findings: Review of the facility's policy "Room to Room Transfers", revised 4/07, indicated, "A resident will be provided with an advance notice of the room transfer. Such notice will include the reason(s) why the move is recommended...Prior to the room transfer, the resident, his or her roommate (if any) and the resident's representative will be provided with information concerning the decision to move...Documentation of the room transfer is recorded in the resident's medical record." This policy was underscored during the 9/11/15 Resident Council meeting. Minutes reflected review of various resident rights, including, "The facility will notify you and interested family member of a room or roommate change." 1. Resident 1's medical history included diagnoses of vascular dementia (brain damage	F 247	F-247 Resident 1 is deemed incapable; the Responsible Party (RP) is satisfied with the current room/roommate. Resident 4 is deemed capable and has no concerns about her current room and roommate. Resident 5 is deemed capable and has no concerns about her current room/roommate. Resident 11 is deemed incapable and his RP has no concerns about his current room/roommate. Resident 12 is deemed capable and she has no concerns about her current room/roommate. Resident 15 was discharged from the facility on 11/18/15.	11-26-15

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F 247	Continued From page 7 from impaired blood flow which may cause impaired reasoning, planning, judgment, memory or other thought processes), anxiety and major depressive disorders. Resident 1's medical record (MR) revealed her room had been changed 6 times [4/29/14, 7/7/14, 12/26/14, 1/23/15, 5/28/15 and 6/3/15] since her initial admission in 4/14, excluding room changes resulting from returns from acute care hospital admissions. Review of her MR reflected room change notification documentation for only 1 of the 6 moves on 7/7/14. 2. According to the Minimum Data Set (MDS- a resident assessment tool), dated 4/3/15, Resident 4 was cognitively intact with a Brief Interview for Mental Status score (BIMS, a test score of 15 indicates resident is cognitively intact) of 15. A record review revealed Resident 4 had room changes 6 times [4/28/15, 5/1/15, 5/28/15, 6/2/15, 6/12/15 and 11/6/15] since her 4/15 admission, excluding room changes after readmissions. Her MR contained room change notifications for only 2 of the moves on 4/28/15 and 11/6/15. In an interview on 11/6/2015 at 1:30 p.m., Resident 4 stated she had not requested any of her room changes. She stated the facility had notified her prior to room change only the first and last times. Resident 4 stated she was never given the opportunity to see the new rooms or meet potential new roommates prior to the room changes. She stated she was notified of the room changes only after the moves had already been initiated.	F 247	For all current and future resident that have the potential to be affected by this deficient practice, the Director of Social Services (DSS) in serviced his assistant and the admission team on 11/24/15 regarding notification and documentation of room moves. When a resident or facility plans on a room change, the social service department will meet with the resident or communicate via telephone with the RP regarding the room change prior to any room moves and show the resident/RP the room available if requested. Once a room has been agreed upon, they will be orientated to the new room/roommate. The SSD or designee will create an observation as documentation to notate the room notification.	11-26-15

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F 247	Continued From page 8 Resident 4 recalled one move in which she was awakened as her Certified Nurse Assistant (CNA) was carrying her belongings out of her room. When the resident asked what the CNA was doing, she was told that she was changing rooms. When Resident 4 asked why, she was not given an answer and her bed was pushed into her new room. 3. According to an MDS dated 9/21/15, Resident 5 had a BIMS score of 15. A record review revealed Resident 5 had 4 room changes [9/27/13, 3/10/14, 12/8/14 and 5/12/15] since her 9/13 admission, excluding room changes after readmissions. Her MR contained room change notifications for only 1 of the 4 moves on 3/10/14. In an interview on 11/6/2015 at 2:00 p.m., Resident 5 indicated she requested most of her room changes, but the facility had notified her prior to room changes only once; the resident stated she was notified of that room changes while in the process of being moved. Resident 5 stated she was never given the opportunity to see the new room or meet her new roommate in advance of the moves. . 4. According to an MDS dated 8/17/15, Resident 11 had a BIMS score of 14. A record review revealed Resident 11 had room changes 5 times [1/18/14, 12/12/14, 12/31/14, 5/13/15 and 5/14/15] since admission in 1/14, excluding room changes after readmissions. His MR contained room change notifications for only 1 of the 5 moves on 12/12/14. 5. According to an MDS dated 10/7/15, Resident 12 had a BIMS score of 11. A record review	F 247	Each week time's 4 weeks, and monthly thereafter, the Medical Records Director (MRD) or designee will audit a list of residents that have had room changes and ensure there is room change notification on the resident record. Any discrepancies will be reported to the SSD for correction, and corrected copies returned to MRD. The SSD will report any non-compliance to the Quality Assurance Committee for recommendations	11-26-15

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F 247	Continued From page 9 revealed Resident 12's room had been changed 4 times [7/18/14, 3/2/15, 5/28/15, and 6/3/15] since her admission in 2/14, excluding room changes after readmissions. Her MR contained no room change notifications. In an interview on 11/6/2015 at 2:15 p.m., Resident 12 stated she did not remember being told of room changes. 6. A facility provided Roster Sample Matrix did not indicate Resident 15 had cognitive impairment. A record review revealed Resident 15 had one room change [9/30/15] since his 9/15 admission, excluding room changes after readmissions. His MR did not include a room change notification. In an interview on 11/6/2015 at 3:30 p.m., Resident 15 stated he had not requested a room change and denied the facility had notified him prior to the room change. Resident 15 stated he was not given an opportunity to see the new room nor meet his new roommate prior to the room change.	F 247		11-26-15
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide and maintain a	F 252	F-252 Resident 13 was provided with a new television on 11/5/15 For all current and future resident that have the	

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F 252	Continued From page 10 homelike environment with use of resident's personal belongings when Resident 13's television had major screen damage and was not replaced or repaired. This failure had the potential to cause psychosocial discomfort and compromise the resident's ability to reach or maintain his highest level of practicable well-being. Findings: 1. On 11/4/15 at 7:52 a.m., Resident 13's flat screen television in his room was observed to have multiple large cracks and over half the screen was black. The only visible and functional portion of the screen was a small section in the right lower corner. In an interview with the Director of Nursing (DON) on 11/4/15 at 3:20 p.m., she stated the television was "broken" and was unsure "how it happened." The DON explained the television was removed from Resident 13's room with permission. Resident 13's responsible party was also notified. The DON further stated the facility would probably be financially responsible to replace the television. In an interview with the Social Services Director (SSD) on 11/5/15 at 2:40 p.m., he stated he was unsure of how the television was damaged or how long it had been damaged. The SSD further stated the television was Resident 13's personal possession and was not broken when brought to the facility. On 11/6/15 and 9:30 a.m., a review of the maintenance log kept at nursing station 2 did not indicate an entry for a broken television.	F 252	potential to be affected by this deficient practice, the DSD in serviced the staff on 11/25/15 to report and document any broken equipment in the maintenance log. The maintenance supervisor (MS) or his designee will review the maintenance log at least 3 times a week and replace/repair equipment as needed. The MS or designee will do environmental rounds weekly times 4 weeks and monthly thereafter to inspect equipment and follow through as needed. The MS will report any non-compliance to the Quality Assurance Committee for recommendations	11-26-15

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F 252	Continued From page 11 Additionally, Resident 13's clinical record kept at nursing station 2 indicated watching television was frequently marked as an activity of choice.	F 252		11-26-15
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive 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, staff interview, and facility policy review, the facility failed to ensure oxygen administration tubing was changed timely when nine days elapsed since it had been changed for Random Resident A (RR A). This failure had the potential to cause an infection or illness in RR A. Findings: In a concurrent observation and interview with LN 1 on 11/3/15 at 8:35 a.m., RR A's oxygen tubing was dated 10/26/15 with black marker. LN 1 confirmed the written date as 10/26/15. LN 1 stated oxygen tubing was to be changed on Sundays by night shift staff. LN 1 also stated that tubing was to be changed every seven days.	F 328	F 328 Radom resident A was discharged home on 11/3/15. For all current and future residents that have the potential to be affected by this deficient practice, the DSD in serviced the Licensed Nurses (LN) on 11/25/15 regarding changing oxygen tubing on a weekly basis. Once a week, the night shift LN will change the oxygen tubing label/bag it by the resident bedside. Weekly times 4 weeks and monthly thereafter, the central supply designee will do rounds to verify that tubing is labeled accordingly.	

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	056410	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 328	Continued From page 12 The facility policy titled "Oxygen Administration", revised October 2014, indicated under section "Care of Equipment", "...1. Change tubing every week...".	F 328	Audits will be provided to the DON to follow as needed. The DON will report any non-compliance to the Quality Assurance Committee for recommendations.	11-26-15
F 371 SS=E	483.35(i) FOOD PROCURE,. STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain their dish racks in a clean and sanitary manner when food debris and heavy water deposits were noted on and surrounding most of the dish racks. This failure had the potential of contaminating clean dishes which came in contact with residents' food and creating a food safety hazard for many residents. Findings: During a tour of the kitchen, conducted on 11/4/2015 at 7:30 a.m., accompanied by the facility's Dietary Supervisors (DS1 & DS2), the dishwashing machine was inspected. DS2 explained the process of how the dirty dishes moved through the dishwashing machine, then how the clean dishes were removed and placed	F 371	**F-371** The dish racks were power washed on 11/5/15 and food debris/hard water deposits removed. The Registered Dietician (RD) in serviced the dietary department staff on proper washing of the dish racks on 11/25/15. The Dietary manager (DM) has created a schedule to have the dish racks power washed on a weekly basis by the dietary staff (dishwashers).	

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F 371	Continued From page 13 on the dish racks. When the dish racks were inspected, they were dirty, stained and unsanitary. The stack of dish racks contained stuck-on food debris, and what DS2 described as, "hard water deposits." When questioned as to how often the dish racks were cleaned, DS1 & DS2 concurred that currently, they do not have a cleaning schedule, but would be power-washed. On 11/5/2015 at 4:15 p.m., a brief walk-through of the kitchen was conducted to follow-up on previous observations that were made. Accompanied by DS1, the dish racks were inspected again. Upon observation, they still had not been power-washed or sanitized and contained food debris and "hard water deposits." This observation showed that the facility had not yet worked on ways to sanitize or eliminate food debris/contaminants from the dish racks.	F 371	The RD will inspect the dish racks on a weekly basis times 4 weeks then monthly thereafter to ensure the dish racks are cleaned and follow up as needed. The RD will report any non-compliance to the Quality Assurance Committee for recommendations.	11-26-15
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425	**F-425** 1. The facility was able to account for the missing Ceftriaxone from the emergency drug kit on 11/4/15 and notification given to the pharmacist. The DON in serviced the licensed nurses on 11/25/15	

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F 425	Continued From page 14 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: 2. During on observation on 11/3/15 at 12:07 p.m. in the medication room at nursing station 1, the emergency medication kit (E Kit) supply description indicated three vials of ceftriaxone (an antibiotic to treat infections) were to be stocked. During a concurrent observation and interview with the Assistant Director of Nursing (ADON), only 1 vial of ceftriaxone was present in the E Kit supply. Only one record was found inside the E Kit. Additionally only 1 entry was noted in the emergency medication administration log to account for 1 vial of ceftriaxone that was used on 10/30/15 at 14:30 (2:30 p.m.). The ADON confirmed 1 vial was removed from the E Kit and 1 vial was not accounted for in the log or within the E Kit. The facility policy titled "Emergency Medications", revised April 2014, indicated "... 8. Any medication that is removed from the emergency kit must be documented on the emergency medication administration log...".	F 425	on use and documentation of medication from the emergency kit. Once the nurse receives orders to give a medication and remove initial dose from the emergency kit, the nurse will document in the emergency log; the name of the resident and dosage used. The Assistant Director of Nursing (ADON) will check the use of the emergency kit and compare against the emergency drug log 3 times a week times 3 weeks and weekly thereafter to ensure proper documentation. Any discrepancies will be presented to the DON for follow up as needed. The DON will report any non-compliance to the Quality Assurance	11-26-15

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F 425	Continued From page 15 Based on observation, interview and document review, the Skilled Nursing Facility (SNF) failed to implement procedures for safe medication documentation when: 1. An admission medication order for 1 of 24 sampled residents (Resident 4) was incorrectly transcribed, and 2. Medication removed from the emergency medication kit (E Kit) was not documented on the emergency medication administration log. These failures had the potential for: 1. Resident 4 to have received 1000 times the ordered dose of a medication, and 2. A medication to not be available for a resident in an emergency situation. Findings: 1. Resident 4's medical record review revealed an order for "Levothyroxine tablet (a thyroid hormone replacement), 150 mcg (micrograms, a unit of measure), amount 150 MG (milligrams, a unit of measure), orally QDNOFD (every day except on Friday). " 150 mcg equals 0.15 mg when converted; 150 mg is 1000 times more than 150 mcg. Review of Resident 4's electronic Medication Administration Record (eMAR) revealed the	F 425	Committee for recommendations. 2. The levothyroxine order transcription error was corrected on 11/5/15. For all current and future residents that have the potential error to be affected by this deficient practice, the DON in serviced the licensed nurses on 11/25/15 to ensure they read the entire medication order and if any discrepancies are noted to notify MD and correct as needed. Medical records staff reviewed the medication orders and clarified any discrepancies. Upon admission of new patients, or changes in medication orders, the Unit clerk will input the orders in the electronic system.	11-26-15

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F 425	Continued From page 16 same order. During an 8:30 a.m., 11/05/15 interview, Licensed Nurse 2 (LN 2) stated she did not notice that the physician order indicated an amount 1000 times the standard dose for levothyroxine. LN 2 stated that when she had questions about a medication order, she verified the eMAR order with the most recent physician order. A concurrent observation of the levothyroxine in the resident's medication drawer reflected small, blue 150 mcg tablets. Review of the medical record revealed an original 3/27/15 SNF physician admission order, written in the acute care hospital discharging Resident 4 to the SNF, which read "Levothyroxine (Synthroid), 150 mcg tab, oral QDayNOFD; 150 mcg = 0.15 mg; take on empty stomach." When initially transcribed by the SNF, however, the order was written as "150 mcg = 150 MG;" on 5/07/15 and 8/21/15, the order was renewed as transcribed. eMARs throughout her stay reflected the incorrect MG dosage. During an 8:35 a.m., 11/5/15 interview, Resident 4 indicated she'd received "only one small blue pill" (levothyroxine) that morning and previous mornings. Resident 4 confirmed she has never received more than one blue pill at a time. During a 3:30 p.m., 11/6/15 interview, the Director of Nursing (DON) stated admission orders were transcribed and entered into the electronic medical record by the unit secretary or the charge nurse. Per the facility's 12/13 "Physician Medication Orders" policy, "The Licensed Nurse will verify or note order electronically by electronic	F 425	The Licensed nurses will then compare and verify the orders by comparing the order input in the system verses the original orders and make any necessary corrections. Medical records staff will audit new orders input weekly times 4 weeks then monthly thereafter. Any discrepancies noted will be given to the DON for follow up. The pharmacist will review residents' medication regimen monthly and final report given to the DON for follow up. The DON will report any non-compliance to the Quality Assurance Committee for recommendations.	11-26-15

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F 425	Continued From page 17 signature...." The DON indicated the medication order was then received electronically by the dispensing pharmacy. If there was a question or concern regarding the order, the pharmacy faxed or called the facility to verify the order. The DON stated that when orders were renewed, existing orders autopopulated so that only the date change had to be entered. After review, the physician signed or electronically signed the renewal. During a phone interview with the SNF's consulting pharmacist (CP), she verified the admission order entry procedure. She stated that if the dispensing pharmacist had an order concern after discussing it with a licensed nurse, the dispensing pharmacist contacted the CP; the CP would then discuss the order with the physician. The CP visited the SNF monthly for 5 days and reviewed every patient's medication orders for accuracy and appropriateness; CP recommendations were then documented in the electronic medical record system and concerns reported to the DON. Monthly reviews of Resident 4's medication regimen by CP from 4/15 through 10/15 failed to note the levothyroxine order discrepancy. In a 10:30 a.m., 11/05/15 interview, the DON stated the medication order had been changed to reflect the correct dosage of 150 mcg. She also verified the resident had not received any incorrect doses. In addition, the nurse practitioner ordered a laboratory test for 11/6/15 to check	F 425		11-26-15

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F 425	Continued From page 18 Resident 4's thyroid hormone level.	F 425		11-26-15
F 441 SS=D	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 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.	F 441	**F-441** C.N.A 1 was in serviced by the DSD on 11/3/15 on food handling. For all current and future residents that have the potential to be affected by this deficient practice, the DSD in serviced the staff on proper food handling on 11/25/15. While handling resident food, the staff will have a barrier between the food and their hands. The DSD will perform rounds 3 times a week times 4 week, and weekly thereafter to ensure the food handling policy is followed accordingly.	

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F 441	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility failed to maintain safe food handling technique while feeding Resident 12. This failure had the potential to transmit disease and cause infection in a population whose immunity may be compromised. Findings: During the Initial Tour of the facility on 11/3/15 at 1:20 p.m., Certified Nurse Assistant 1 (CNA 1) was setting up the lunch tray for Resident 12. As the surveyor walked into the resident's room, CNA 1 was observed holding Resident 12's cheese sandwich with her bare hands. CNA 1 commented to Resident 12, "It is very hot" and put the sandwich down on the plate. She then picked up the sandwich again with her bare hands and again repeated, "It is very hot" while dividing the sandwich with her hands and handing a piece to Resident 12. In a concurrent interview when CNA 1 was asked if she should be handling the resident's food with her bare hands, she responded that she had washed her hands. When she was further asked what was the expected practice, she responded that she should have worn gloves. During an interview with the Director of Staff Development on 11/6/15 at 8:10 a.m., she was asked about her expectation of staff handling	F 441	The DSD will report any non-compliance to the Quality Assurance Committee for recommendations.	11-26-15

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F 441	Continued From page 20 residents food with bare hands when assisting them. She concurred that staff should wear gloves when directly handling resident food. During a review of the facility's 2012 "Assistance with Meals" policy, it stipulated, "Employees assisting residents during meals and handling food will practice safe food handling techniques by ensuring that food materials are not handled with bare hands...."	F 441		11-26-15
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and document review, the facility failed to maintain a safe, functional, clean and homelike environment for residents, staff and visitors when there was: 1. Uneven flooring in room 207, 2. A chipped and broken window sill in room 110, 3. An overbed table with chipped and missing laminate in room 208 B, 4. A chipped and scraped bathroom door in room 100, and an 5. Unsanitary chair in room 106 A. These failures had the potential to decrease the homelike experience for residents and increase the potential for injury for residents, staff and visitors.	F 465	F-465 1. The uneven floors were replaced on 11/10/15. 2. The window sill was replaced on 11/9/15. 3. The overhead table was replaced on 11/10/15. 4. The parts to fix the bathroom door were ordered on 11/23/15. 5. The unsanitary chair was removed from room 106 and a new chair was provided on 11/6/15.	

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	056410	A. BUILDING _____ B. WING _____	11/06/2015

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F 465	Continued From page 21 Findings: 1. During the Environmnental Tour with the Maintenance Supervisor (MS) on 11/4/15 at 11:30 a.m., uneven flooring was observed in room 207. The resident in 207 B commented that the uneven flooring, the result of a crack, caused her wheelchair to become caught in the crevice and led Certified Nurse Assistants (CNAs) to trip at night. During a concurrent interview with the MS, he stated the crack was caused by a tree root in the patio outside the residents' room. He said he had placed yellow tape over the crack to decrease the potential for tripping; however, the tape was not observed over the crack during the tour and floor was uneven. The crack measured 90 inches in length and extednded from the middle of the residents' room to their bathroom door. 2. During the Initial Tour of the facility on 11/3/15 at 9:45 a.m., the window sill in room 110 was observed to be scraped and chipped. In an interview on 11/4/15 at 11 a.m., the MS stated, "We knew about [the condition of the window sill], ordered the materials and have been waiting for them." However, the MS was unable to provide documentation that repair materials had been ordered. 3. During a follow-up of the Initial Tour on 11/4/15 at 11:30 a.m., an overbed table in 208 B was observed to be chipped, with splintered edges and exposed materials. In a concurrent interview with the MS, he	F 465	The staffs were in serviced by the DSD on 11/25/15 to report and document in the maintenance log equipment noted to be broken or worn out. The maintenance supervisor (MS) or his designee will review the maintenance log at least 3 times a week and replace/repair equipment as needed. The administrator in serviced the MS on 11/24/15 to perform rounds and inspect equipment and make any necessary repairs. The MS or designee will do environmental rounds weekly times 4 weeks and monthly thereafter to inspect equipment and follow through as needed.	11-26-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 22 responded that a new table was needed for the room. 4. During the Initial Tour on 11/3/15 at 7:30 a.m., the lower 1/4 of the bathroom door in room 100 was observed to be scraped and chipped During an interview on 11/4/15 at 11:30 a.m., the MS commented, "It is ugly. We are going to replace the door. It may be from the wheelchairs." 5. During the Initial Tour of the facility at 11:40 a.m., 11/3/15, a very dirty cloth-covered folding chair was observed in room 106 A, near the head of the bed. During a concurrent interview, the MS commented, "It needs to be washed. It is very dirty. The CNAs should have let the maintenance staff know and put a request in the Maintenance Log at the nurse's station." No request was observed in the nursing station maintenance log book. In a concurrent interview with CNA 2 who was assigned to the resident, she commented that "The chair looks old and dirty. It should have been taken to Maintenance to get it washed." During review of the facility's 2009 policy and procedure titled "Maintenance Service," it stipulated, "Maintaining the building in good repair...maintenance log will be available at both the nursas [stations] to document anomalies." During an interview with Director of Staff Development on 11/4/15 at 8:30 a.m., she indicated that during staff orientation, employees were instructed to write any needed repairs in the	F 465	The MS will report any non-compliance to the Quality Assurance Committee for recommendations	11-26-15

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F 465	Continued From page 23 maintenance log/and or communicate them to the Charge Nurse if the situation was serious and requied immediate attention.	F 465		11-26-15

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acceptable POC 1/14/16

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A 000	Initial Comments The following reflects the finidngs of the California Department of Public Health during a Recertification survey. Representing the Department of Public Health: HFEN, 29917/1958 HFEN, 35598/2004	A 000	**PLAN OF CORRECTIONS** **"This plan of correction is prepared as part of the quality assurance process for the provider. This plan of correction and any attached documents are prepared with substantial reliance upon privileged peer review information and/or reports and as such are protected from discovery."** **"This plan of correction is prepared, submitted and/or executed solely because it is required by local, state and/or federal regulations, codes, and or guidelines. As this transmission is required by law, it is not a waiver of the provisions within applicable laws and regulations or any other codes, statutes or regulations."**	12-26-15
A 345	T22 DIV5 CH3 ART3-72349(a) Dietetic Service--Equipment and Supplies (a) Equipment of the type and in the amount necessary for the proper preparation, serving and storing of food and for proper dishwashing shall be provided and maintained in good working order. This Statute is not met as evidenced by: Based on observations, document review, staff and patient interviews, the facility failed to provide sufficient equipment and supplies for patients' use to meet their dining needs. On different days of the survey, the facility ran out of silverware and 8 ounce (oz) bowls and failed to provide patients with the proper eating utensils. Patients who were unable to cut and/or easily consume their meals were at risk for nutritional deficit. This was a great inconvenience to patients who were unable to cut their food and/or easily consume their meal. Findings: During the initial tour of the facility, conducted on 11/3/2015 at 7:30 a.m., Patients 4, 5 and Random Patient C, complained about the utensils they were given during breakfast. All three patients	A 345		

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE RN | (X6) DATE 1-14-16

PRINTED: 11/18/2015
FORM APPROVED

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
	CA030000105	A. BUILDING: _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITNEY OAKS CARE CENTER	3529 WALNUT AVENUE CARMICHAEL, CA 95608

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A 345	Continued From page 1 had a table spoon in place of a teaspoon, and a butter spreader in place of a knife. Patients complained not being able to cut their waffles with a butter spreader and expressed having difficult eating their yogurt and cereal with a large table spoon rather than a teaspoon. The patients also shared that they were not served coffee with their breakfast that morning because there were not enough clean coffee cups in the kitchen. On 11/04/15 at 7:20 a.m., accompanied by the facility's dietary supervisor (DS 1), the breakfast tray line was observed. The hot cereal, which consisted of cream of wheat, was being served in 8 oz. bowls. However, before all the patient trays had been served, the facility ran out of bowls and stopped the tray line to search for more bowls. Since none were found, they began serving the hot cereal in 2 separate servings, in two 4 oz bowls. When DS 1 was asked about their supply of bowls, he replied that many of their bowls were dirty and had not been washed. But, when DS 1 and the dietician were later questioned if they had enough supply of bowls and silverware, they acknowledged that they were short on some supplies and would have to bring out more silverware from their stock, and purchase more 8 oz. bowls. Review of the Resident Council Minutes Report for 9/11/15, conducted on 11/3/15, showed that patients had complained in September, that the facility did not have enough silverware for all the patients. So, the Resident's Council suggested that the facility obtain more silverware. The Dietary Department was made aware of the patients' complaints and promised they would resolve the issue by meeting their requests. Their plan of action was to obtain more	A 345	**A 345** The facility purchased the 90z bowls. They were delivered on 11/10/15. The facility had extra silver ware in stock. They were pulled and added to current inventory on 11/5/15. The registered Dietician (RD) in serviced the dietary staff on 11/25/15 to notify her or designee if shortage of supply/equipment is noted. The Dietary manager performed an inventory of dietary supplies/equipment on 11/1015 and added supplies as needed. The RD or designee will perform routine inventory, any shortage of supplies will be ordered and added to inventory.	12-26-15

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A 345	Continued From page 2 silverware. On November 3, 2015, two months after the patients had initially complained to the facility of the shortages of kitchen supplies, they still did not have enough teaspoons or mugs to serve coffee, and patients were still being given a butter spreader in place of a knife. This continual shortage of supplies demonstrated that the facility did not make an effort to accommodate and meet all patients' dietary needs.	A 345	The RD will report any non-compliance to the Quality Assurance Committee for recommendations.	12-26-15
A 438	T22 DIV5 CH3 ART3-72377(b)(2) Pharmaceutical Service--Equipment and Supplie (b) Emergency supplies as approved by patient care policy committee or pharmaceutical service committee shall be readily available to each nursing station. Emergency drug supplies shall meet the following requirements: (2) The emergency drug supply shall be stored in a portable container which is sealed in such a manner that the tamper-proof seal must be broken to gain access to the drugs. The director of nursing service or charge nurse shall notify the pharmacist when drugs have been used from the emergency kit or when the seal has been broken. Drugs used from the kit shall be replaced within 72 hours and the supply resealed by the pharmacist. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure emergency medication supplies were replaced within 72 hours which had the potential to cause patients to not receive necessary medications in a life threatening situation or cause a delay in treatment.	A 438	**A-438** The emergency drug kits were replaced on 11/3/15. The Director of Staff development in serviced the licensed nurses on 11/25/15 to ensure that once a drug kit is opened, they are to notify the pharmacy and request for the kit to be replaced. The Assistant Director of nurses will check for e kit use at least 3 times a week. If the kit is opened and medication	

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A 438	Continued From page 3 Findings: During an observation on 11/3/15 at 12:07 p.m., the Emergency Medication Kit (E Kit) at nursing station medication room number 1 was observed to have had nine documents indicating nine medications were removed from the kit. In a concurrent interview and observation with the Assistant Director of Nursing (ADON), she confirmed nine medications had been documented as removed. The first medication removed from the E Kit was lorazepam (a medication used to treat anxiety) on 10/24/15 at 1900 (7:00 p.m.). The ADON stated the medication should have been replaced by 10/27/15. The ADON confirmed 10 days had elapsed since the medications were to be replaced by pharmacy. During a concurrent observation and interview with LN 3 at nursing station medication room 2 on 11/3/15 at 12:45 p.m., the E Kit had medication first removed on 10/30/15. LN 3 stated that medication should have been replaced by 11/2/15. LN 3 confirmed 1 day had elapsed since the medications were to be replaced by the pharmacy. During an interview with the consultant pharmacist on 11/3/15 at approximately 3:00 p.m., she stated the expectation was for nurses to call the pharmacy for E Kit medication replacement "immediately". She further stated medication was typically replaced within 24 hours.	A 438	removed, they will contact the pharmacy and request for a replacement. The Director of nurses will perform routine random checks of the emergency kit and ensure they are ordered accordingly. The DON will report any non-compliance to the Quality Assurance Committee for recommendations.	12-26-15