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 02/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR NURSING CENTER	900 NORTH CHURCH STREET LODI, CA 95240 POC Accepted RLowry 2/4/14

(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 an abbreviated survey of entity reported number CA000384723. Representing the Department: HFEN 29825 Inspection was limited to the specific entity reported incident and does not represent 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.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and review of the clinical record and facility policy and procedure, the facility failed to implement written policies and procedures that prohibit abuse of residents when an injury of unknown origin was not reported within 24 hours to the administrator and state licensing and certification agency. This failure had the risk on ongoing resident abuse. Findings: Resident 1 was admitted to the facility on 1/21/09 with diagnoses including loss of ability to understand or express speech, brain	F 226	**F226** Immediate corrective action for those Residents affected by the deficient practice; On 1/20/2014, Director of Nursing (DON) and Assistant Director of Nursing (ADON) reviewed facility 24 hour reports, Change of Condition (COC) Reports and other daily audits. The DON immediately verified the physical condition of the resident and began an investigation. Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action to be taken; ADON reviewed all daily reports on 1/20/2014 and found no other residents affected. Facility measures and systemic changes to ensure the deficient practice does not recur; Director of Staff Development (DSD), will in-service all Licensed Nurses regarding process for Injuries of Unknown Origins (IUO), including investigating, documenting and reporting. DSD will in-service all Licensed Nurses on Prevention of Abuse for Mandated reporters. The DON, ADON or Nursing Supervisor will review all daily reports, including weekends. Any IUO will be reviewed to ensure safety of the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tyrus [illegible]	Administrator	2-13-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	Continued From page 1 hemorrhage, paralysis of the right side of the body, generalized anxiety and pain. Resident 1's medical record was reviewed: Resident 1's document titled Change of Condition ..., dated 1/17/14, indicated "swelling & discoloration to (R) upper arm which "started 1/17/14" . MD 1 had been notified at 3 p.m. Resident 1's document titled Nurses Notes, dated 1/18/14 at 1 a.m., established "X-ray results of Resident ® arm as follows, acute proximal (nearest the heart) shaft fracture ..." Review of Resident 1's care plan titled Fractures/Trauma, dated 1/18/14, indicated "fracture" and "tissue swelling". During an interview with Licensed Nurse 1 (LN 1) on 1/28/14 at 2:33 p.m., she said the day shift told her they had filled out the change of condition form and "reported everything ". She did not fill out the SOC 341. Review of the SOC 341 (a confidential report of suspected dependent/elder abuse) was faxed to the Department on Tuesday, 1/21/14 at 6:25 a.m., 77 hours after the X-ray results were received. It had not been reported to the Department within 24 hours as required by facility policy and procedure. The facility policy and procedure titled Abuse Prevention, Intervention, Investigation & Crime Reporting Policy, revised September 2011, established "It is the responsibility of employees to promptly report to the facility administrator, local ombudsman (or local law enforcement	F 226	resident, proper documentation and proper notification and reporting has been done. Health Information Management Staff (HIM) will audit COCs per audit schedule and report all incomplete documentation. Inter-Disciplinary Team (IDT) will round on COCs involving IUO and assist in further investigation as needed. DON or Administrator will complete documentation for the investigation and report per policy. Facility plan to monitor corrective actions and sustain compliance; integrate Quality Assessment and Assurance (QAA) Process: All incidents will be entered into facility tracking system by HIM, including IUO. DON or Administrator will review incidents weekly using tracking/trending reports. Any issues will be communicated to IDT for follow up. DON or Administrator will provide QAA with monthly tracking reports of incidents. Trends will be discussed in QAA. QAA will monitor and make recommendations. Completion Date: 02/28/14	

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F 226	Continued From page 2 agency), and to the State Licensing and Certification immediately or as soon as practicably possible within 24 hours of detection, any incident of suspected or alleged neglect or resident abuse from other residents, staff, family, or visitors; including injuries of unknown source ..." The same policy and procedure defined Injury of Unknown Source as "an injury that was not observed by any person OR the source of the injury could not be explained, AND the injury is suspicious because of the extent of the injury, or location of the injury (in an area that is not normally prone to trauma) ..." During an interview with the Administrator on 1/27/14 at 2:12 p.m., she said," The nurses didn't tell us [Director of Nurses or Administrator]. The X-ray results reported to the MD on 1/18/14 at 1 a.m. indicated a fractured right humerus. She stated "We didn't know about it until we went through paperwork on Monday [1/20/14]. Staff [who discover an injury of unknown origin] are supposed to send in the SOC 341."	F 226		