California Department of Public Health — Accepted POC with [redacted] RN / Admin decision

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA070000096	A. BUILDING 8/31/11 @ 8:30 am B. WING	08/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD GARDENS	1601 PETERSEN AVENUE [redacted] SAN JOSE, CA 95129

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
AUG 30 2011
LICENSING & CERTIFICATION PROGRAM

(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 (CDPH) during a licensing survey conducted from 8/8/11 through 8/10/11. Representing the CDPH: 17536, Health Facilities Evaluator Nurse. The facility was licensed for 258 beds. The census at the time of the survey was 234 with two bed holds. There were 8 sampled patients.	A 000	**This document is not an agreement or disagreement with the summary of deficiencies. It is intended as a Plan of Correction as required by law. It is intended to constitute a written and credible allegation of compliance with the deficiencies listed.** **A227**	
A 227	T22 DIV5 CH3 ART3-72319(d) Nursing Service--Restraints and Postural Supp (d) Restraints of any type shall not be used as punishment, as a substitute for more effective medical and nursing care, or for the convenience of staff. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure two of eight sampled patients (15 and 17) were not restrained for the convenience of staff. There was no documented evidence Patients 15 and 17 were assessed to determine the least restrictive method of addressing their risk of falls. Findings: 1. Patient 15 was admitted to the facility with diagnoses including dementia and dysphagia (difficulty in swallowing and chewing). The 4/7/11 Minimum Data Set (MDS, an assessment tool) indicated Patient 15 was moderately impaired in cognition, required extensive assistance in her activities of daily living, her balance during transitions and walking was not steady, and she	A 227	Amberwood Gardens shall reinforce it procedures to ensure and provide appropriate documentation with reference to the use of restraints and ensure that they are not used as a substitute for more effective medical and nursing care, or for the convenience of staff. The Director of Staff Development shall give an in-service to the Licensed Nurses with reference to the facilities policy and procedure with reference to restraints. They should ensure that the less restrictive method is used if any restraint is needed at all. The newly formed Restraint committee shall review residents 15 and 17 for their restraint need. The team shall also review all facility restraints to ensure that no other residents should have the same issue.	9/15/11

Licensing and Certification Di[redacted]

LABORATORY DIRECTOR'S OR[redacted] SENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 8/29/11

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A 227	Continued From page 1 was only able to stabilize with human assistance. Her physician indicated in a 6/2/11 assessment Patient 15 did not have the ability to understand and make decisions. The health record identified a family member as her responsible party (RP). Record review indicated her physician issued an order dated 2/26/11 for staff to apply a seat belt when Patient 15 was up in chair for "patient safety due to episode of getting out of wheelchair unassisted". During an interview on 8/8/11 at 1:40 p.m. licensed nurse A (LN A) stated the RP gave her telephone informed consent for the seat belt. LN A stated Patient 15 could not remove the seat belt by herself. LN A stated without the seat belt Patient 15 would stand up without calling for help and was at risk for falling down because of her poor standing balance. LN A stated Patient 15 could maintain a steady balance while sitting in a chair. On 8/8/11 at 2:00 p.m. Patient 15 was observed in the patient congregation area where the television was located. The seat belt was applied around her waist. Patient 15 did not respond when engaged in conversation. During an interview on 8/8/11 at 3:15 p.m. certified nurse assistant B (CNA B) stated Patient 15 is at risk for falling without the seat belt. The progress note dated 4/13/10 indicated "RP came and went inside the room and found resident lying on the floor on her right side opposite the head of the bed. Resident night gown was halfway off where the alarm was clipped and found unclipped".	A 227	The Individual Nurse Unit Managers shall have the responsibility for on going and continuing monitoring for compliance with the regulation. They shall do this in coordination with the Restraint Management Committee by means of an individual review or any / all new restraint utilization/ orders. Also, the committee shall maintain a review and documentations of all the facilities restraint use within their monthly meetings. Any unresolved issue with restraints shall be referred to the CQI team for resolution. CALIFORNIA DEPARTMENT PUBLIC HEALTH AUG 30 2011 L & C DIVISION SAN JOSE	

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A 227	Continued From page 2 The progress note dated 5/2/10 indicated "resident was seen lying on the floor on her right side of body on top of the landing pad beside her bed". The progress note dated 2/26/11 indicated "received a telephone order from Dr. ____: apply seat belt when up in wheel chair as a safety device due to episode of getting out of wheel chair unassisted". During an interview on 8/9/11 at 9:30 a.m. licensed nurse C (LN C), the station 5 unit manager, stated she did not know where Patient 5 was, (chair or bed) prior to the falls on 4/13/10 and 5/2/10 because both falls were unwitnessed LN C stated the 4/13/10 note did not indicate whether the wheelchair alarm sounded before the fall. LN C stated she could not find documented evidence Patient 15 had additional falls after her last documented fall on 5/2/10 up to the issuance of the seat belt order on 2/26/11, a period of ten months. LN C stated there were no less restrictive measures attempted prior to the application of the seat belt. 2. Patient 17 was admitted to the facility with diagnoses including dementia and kidney failure. The 7/8/11 MDS indicated Patient 17 was severely impaired in cognition, required extensive assistance in her activities of daily living, had limited mobility when in bed, and her balance during transitions and walking was not steady and she was only able to stabilize with human assistance Her physician indicated in a 9/9/10 assessment Patient 17 did not have the ability to understand and make decisions. The health record identified a family member as her RP	A 227		

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A 227	Continued From page 3 The health record indicated an order dated 7/2/11 (readmission date) for staff to "apply soft roll belt while in bed as resident gets up without assistance due to poor safety awareness related to dementia". During an interview on 8/9/11 at 8:45 a.m. licensed nurse D (LN D), the unit 1 manager, stated Patient 17 could get up from bed if she did not have the roll belt and was at risk of falling from bed. LN D stated she could not find evidence the resident had fallen from her bed since she was initially admitted on 9/8/10. LN D stated the facility did not try less restrictive measures before the roll belt was applied On 8/9/11 at 9:45 a.m. Patient 17 was observed lying in her bed with her eyes closed. LN D was asked to check the roll belt. LN D lifted part of the bed cover and stated the roll belt was not even applied. The nurse assistant in the room stated the hospice aide removed it and had not applied it. LN D stated Patient 17's safety while in bed was not at risk even if she did not have on the roll belt. The facility policy/procedure on use of restraints dated December 2008 indicated "if the resident cannot remove a device in the same manner in which the staff applied it given the resident's physical condition, and this restricts his/her typical ability to change position or place, that device is considered a restraint". Step 6 of the procedure indicated "prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints."	A 227		

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A 227	Continued From page 4 The health records of Patients 15 and 17 did not contain a prerestraining assessment. During their interviews on 8/9/11 at 9:30 a.m. and 9:45 a.m. respectively, LN C and LN D stated there was never an assessment prior to starting the restraint on 2/26/11 for Patient 15 and 7/2/11 for Patient 17. Step 16 of the procedure indicated "restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination." Patient 15 was not assessed three months after 2/26/11 to determine whether she was a candidate for restraint reduction or elimination.	A 227		
A 256	T22 DIV5 CH3 ART3-72321(c)(2) Nursing Service--Patients with Infectious Dis (c) The following shall be available in each nurse's station: (2) Name, address and telephone numbers of local health officers. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure the name, address, and telephone numbers of local health officers were available in five of five nurse's stations. Findings: During the tour of the nurse's stations at the following times with the director of nursing service (DNS) the name, address, and telephone numbers of local health officers was not available	A 256	A256 The facility shall ensure that the required information is available in each nurse's stations, including the Name, address, and telephone numbers of local (county) health officers. The DNS will obtain the required information form the county health offices and cause it to be available at each nursing station. In addition the DSD shall give and in-service to the Licensed Nurses on the location and use for such information. The DSD shall ensure that the information is present and current at each station to assure continuing compliance with the regulation. She shall do this by a monthly check of the documentation at each station.	9/15/11

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A 256	Continued From page 5 in each station: Station 5 (dementia unit) on 8/8/11 at 9:00 a.m.: licensed nurse C (LN C) stated she could not find the information when asked by the DNS. Station 1 (short term unit) on 8/8/11 at 9:10 a.m.: licensed nurse D (LN D) stated the contact information was not available when the DNS asked. Station 2 (long term unit) on 8/8/11 at 9:25 a.m.: licensed nurse E (LN E) stated the station did not have the information. Station 3 (long term unit) on 8/8/11 at 9:30 a.m.: The DNS stated the information was not available. Station 4 (subacute unit) on 8/8/11 at 9:40 a.m.: The DNS stated the information was not available.	A 256	Any issue or problem shall be referred to the CQI team for action.	
A 738	T22 DIV5 CH3 ART5-72503(a)(2) Consumer Information to Be Posted (a) The following consumer information shall be conspicuously posted in a prominent location accessible to the public. (2) A listing of all services and special programs provided in the facility and those provided through written contracts. This Statute is not met as evidenced by: Based on review of posted information and interview, the facility failed to ensure a list of	A 738	A738 The Facility shall ensure that all required consumer information shall be posted in a conspicuously and prominent location accessible to the public. The Administrator shall put a listing of all services and special programs provided in the facility within its glass posting board. He shall monitor for continuing compliance by his daily rounds and visual observation of the information thereon posted.	9/15/11

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A 738	Continued From page 6 services and programs provided by the facility was conspicuously posted in a prominent location accessible to the public. Findings: During a tour of the consumer information area near station 1 on 8/8/11 at 10:05 a.m. the list of services and programs provided by the facility was not seen. During an interview on 8/8/11 at 10:05 a.m. the administrator stated the list of services and programs provided by the facility was not posted in the consumer information area so it was accessible to the public.	A 738	Any problem with the postings shall be reported to the CQI team to ensure compliance.	
A 739	T22 DIV5 CH3 ART5-72503(a)(3) Consumer Information to Be Posted (a) The following consumer information shall be conspicuously posted in a prominent location accessible to the public. (3) The current and following week's menus for regular and therapeutic diets. This Statute is not met as evidenced by: Based on review of posted information and interview, the facility failed to post the current and following week's menus for regular and therapeutic diets in two of five nurse's stations accessible to the public. Findings: During a tour of the following nurse's stations on 8/8/11 at the following times, the current (8/8/11 through 8/14/11) and following week's (8/15/11 through 8/21/11) menu was not seen posted. Instead, the menus posted were for the week 7/18/11 through 7/24/11 and the following week 7/25/11 through 7/31/11.	A 739	The facility shall ensure that the consumer information including the current and following week's menus for regular and therapeutic diets is posted in a prominent location accessible to the public. The main dietary information board is located in the station 1 hallway by the dietary department. The facility also has various other (5) boards located through out the facility with reference to our select menu and resident choice options and dietary notice. The Administrator with the help of the dietary department shall ensure that these postings are all current with reference to the menus. The Administrator shall update the postings now and he shall ensure that they comply with regulation by means of his daily rounds and visual observations of the postings.	9/15/11

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A 739	Continued From page 7 On 8/8/11 at 8:50 a.m.: Station 5 (dementia unit) had the previously dated menus on the wall across from the dining room. On 8/8/11 at 9:30 a.m.: Station 3 (long term unit) had the previously dated menus on the wall near the fire extinguisher. During an interview on 8/8/11 at 9:45 a.m. the administrator stated the current and following week's menus posted on stations 3 and 5 needed to be replaced as they were outdated. The administrator stated the public accessed the information regarding the current and following week's menus by going to the respective nurse's station.	A 739	Any issue shall be referred to the CQI team for action.	
A1024	T22 DIV5 CH3 ART5-72547(a)(16) Content of Health Records (a) A facility shall maintain for each patient a health record which shall include: (16) An inventory of all patients' personal effects and valuables as defined in Section 72545 (a) (12) made upon admission and discharge. The inventory list shall be signed by a representative of the facility and the patient or his authorized representative with one copy to be retained by each. This Statute is not met as evidenced by: Based on record review and interview, the facility failed to ensure the inventory list of personal property for one of eight sampled patients (17) was signed by the responsible party (RP) or noted as to the facility's efforts to contact the RP for his signature. Findings:	A1024	A1024 Amberwood Gardens shall maintain for each resident a health record that includes an inventory of the resident's personal effects and valuables, made upon admission and discharge; it shall be signed by a facility representative and the resident or their authorized representative. The Director of Social Work shall give an in-service to their staff with reference to the need to ensure that the resident or RP has signed the inventory list as the policy and regulation require. Resident 17's RP shall be notified and requested to sign their form. Each individual's social worker shall review their client's inventory list to	9/15/11

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A1024	Continued From page 8 Patient 17 was admitted to the facility with diagnoses including dementia and kidney failure. The 7/8/11 MDS indicated Patient 17 was severely impaired in cognition. Her physician indicated in a 9/9/10 assessment Patient 17 did not have the ability to understand and make decisions. The health record identified a family member as her RP. The inventory list dated 9/8/10, had the signature of the facility's representative but it did not contain the signature of Patient 17's RP. There was no other notation on the form of the facility's efforts to contact the RP for his signature. During an interview on 8/9/11 at 9:30 a.m. licensed nurse D (LN D) stated the inventory list was not signed by the RP and did not contain information the facility attempted to communicate with the responsible party to obtain his signature.	A1024	ensure that no other resident has the same issue. The Director of Social Service shall monitor for continuing compliance by a review of each new admissions /discharge chart. Medical Records shall assist in the monitoring within their ongoing chart audits with reports to the various departments. Any problems shall be referred to the CQI team for resolution.	
A1065	T22 DIV5 CH3 ART5-72553(d)(4) Fire and Internal Disasters (d) The evacuation plan shall be posted throughout the facility and shall include at least the following: (4) Emergency telephone number of the local fire department. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure the evacuation plan in the event of an emergency contained the emergency telephone number of the local fire department in five of five sites. Findings:	A1065	A1065 This facility shall have the evacuation plan posted throughout the facility and it shall include the emergency telephone number of the local fire dept. The Administrator shall in-service the Maint department on the need to ensure that the plans they post and that are approved must include the 911 number at a minimum on each plan. The Maint director shall post new evacuation plans where the old ones were however they shall include the required information.	9/15/11

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A1065	Continued From page 9 During a tour of the following sites with the director of nursing service (DNS) where the evacuation map in the event of evacuation due to an emergency such as a fire, was posted, the telephone number of the local fire department was not on the map: 1. On 8/8/11 at 9:00 a.m. station 5 (dementia unit) on the wall near the dining room 2. On 8/8/11 at 9:15 a.m. on the wall across from station 1 3. On 8/8/11 at 9:25 a.m. on the wall near the sink at station 2 4. On 8/8/11 at 9:30 a.m. on the wall near the fire extinguisher across from station 3 5. On 8/8/11 at 9:35 a.m. on the wall facing station 4 (subacute unit) During an interview on 8/8/11 at 9:35 a.m. the DNS stated she would notify the administrator.	A1065	The Administrator and Maint. director shall monitor for continuing compliance via their daily rounds and visual observation of the various postings including the evacuation plane. Should there be any issue it shall be referred to the CQI team for resolution.	
A1177	T22 DIV5 CH3 ART6-72623(c)(3) Laundry (c) Laundry areas shall have, at a minimum, the following: (3) Separate linen carts labeled "soiled" or "clean linen" and constructed of washable materials which shall be laundered or suitably cleaned as needed to maintain sanitation. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure the facility labeled the laundry carts intended to contain the clean and soiled linen as "clean" and "soiled" respectively.	A1177	A177 The facility shall in the laundry areas have at a minimum separate linen carts labeled "soiled" or "clean". The DSD shall in-service the Maint , HK and Laundry staff with reference to this requirement. The Maint Supervisor shall obtain labels and place them on our various carts as either "clean" or "soiled".	9/15/11

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A1177	Continued From page 10 Findings: During a tour of the laundry area on 8/8/11 at 10:30 a.m. carts containing clean and soiled linen were not labeled as "clean" and "soiled" to indicate the type of linen stored in them. During an interview on 8/8/11 at 10:30 a.m. the maintenance supervisor (MS) who also was the laundry supervisor, stated he did not know of this regulatory requirement but he would label the carts as either "clean" or "soiled" depending on what each cart contained.	A1177	The Administrator, Maint Director, HK lead and DSD shall monitor for continuing compliance with this requirement. This by their daily rounds and observation of the carts. Any issue shall be referred to the CQI team for action.	
A1178	T22 DIV5 CH3 ART6-72623(d) Laundry (d) Written procedures for handling, storage, transportation and processing of linens shall be posted in the laundry and shall be implemented. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure written procedures for handling, storage, transportation and processing of linens were posted in the laundry area to be implemented by laundry staff. Findings: During a tour of the laundry area on 8/8/11 at 10:30 a.m. with the maintenance supervisor (MS) who also supervised the laundry staff, there were no written procedures posted in the laundry area for the laundry staff to follow. During an interview on 8/8/11 at 10:30 a.m. the MS stated there were no written procedures posted in the laundry area for staff to follow in handling, storage, transportation, and processing of linens.	A1178	A1178 The facility shall establish new written procedures for handling, storage, transportation and processing of linens and ensure that they are posted in the laundry and implemented by same. The Administrator shall, with input from the QA team create a policy and procedure as required and the DSD shall in-service the Laundry staff on same. The Maint supervisor shall cause it to then be posted in the laundry. The Maint Super, HK lead and the Administrator shall monitor for continuing compliance by their daily rounds and visual observation for the posting.	9/15/11

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A1178	Continued From page 11 When asked during an interview on 8/10/11 at 1:15 p.m., the administrator stated the facility had no written laundry procedures.	A1178	An issue shall be referred to the CQI team for resolution.	
A 005	1263(c) Health & Safety Code 1263 (c) Any certified nursing assistant employed by a skilled nursing facility or intermediate care facility shall participate in a minimum of five hours of dementia-specific in-service training per year, as part of the facility's in-service training. This Statute is not met as evidenced by: Based on review of personnel records and interview, the facility failed to ensure three of four current certified nurse assistants (CNA) and one of one terminated CNA participated in a minimum of five hours of dementia-specific in-service training per year following the hire year. Findings: On 8/10/11 the personnel files of the following three active staff and one terminated staff were reviewed with licensed nurse F (LN F), the acting staff developer. Certified nurse assistant G (CNA G) hired on 12/26/07 Certified nurse assistant H (CNA H) hired on 7/28/08 Certified nurse assistant I (CNA I) hired on 8/3/09 Certified nurse assistant J (CNA J) hired on 8/17/09 and terminated on 6/1/11 The personnel file of CNA G indicated she had one hour of dementia-specific in-service training in 2008, and was short four hours for that year. CNA G did not have dementia-specific training for 2009 and was short of three hours for the year 2010.	A 005	A005 It is the policy of Amberwood Gardens to provide the minimum of five hours of dementia specific in-service per year. The DSD shall review the noted C N A's to ensure that they attend the offered in-services so as to obtain the required training. Also the DSD shall ensure that the required trainings are offered and that failure to attend the required hours is noted and resolved. The DSD will review the C N A's records for the year 2011 to ensure that there is compliance for said year. The DSD shall establish a roster of C N A's and maintain a tracking of the dementia specific training of these staff so as to ensure that they all receive the training and to maintain a continuing monitoring of the compliance with the requirement. The DSD shall refer any issue with compliance to the CQI team for resolution.	9/15/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA070000096	A. BUILDING _____ B. WING _____	08/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD GARDENS	1601 PETERSEN AVENUE SAN JOSE, CA 95129

(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 005	Continued From page 12 The personnel file of CNA H indicated she did not have dementia-specific training for the years 2009 and 2010. The personnel file of CNA I indicated she did not have dementia-specific training for the year 2010. The personnel file of CNA J indicated he did not have dementia-specific training for the year 2010. During an interview on 8/10/11 at 11:45 a.m. LN F stated the training records indicated the four CNAs mentioned above did not get the minimum five hours per year of dementia-specific training for the years following their year of hire.	A 005		