STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000022	A. BUILDING _____ B. WING _____	C 07/27/2011

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

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A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of Complaint #CA00276869. Representing the Department of Public Health: HFEN, 1946/29821 The inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility.	A 000	**DISCLAIMER STATEMENT** Preparation, submission and implementation of the Plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. This Plan of Correction is submitted as the facility's credible allegation of compliance.	
A 034	1418.7(b) Health & Safety Code 1418 (b) The facility program shall include all of the following: (1) Establishment and posting of the facility's theft and loss policies. (2) Orientation of employees to those policies. (3) Documentation of theft and loss of property with a value of twenty-five dollars ($25) or more. (4) Inventory of patient's personal property upon admission. (5) Inventory of and surrender of patient's personal property upon death or discharge. (6) Regular review of the effectiveness of the policies and procedures. (7) Marking of patient's personal property, including dentures and prosthetic and orthopedic devices. (8) Reports to local law enforcement of stolen property with a value of one hundred dollars ($100) or more. (9) Methods for securing personal property. (10) Notification of residents and families of the facility's policies. This Statute is not met as evidenced by:	A 034	**A034-1418.7 (b)** a) The corrective action to be accomplished for the patient identified to have been affected by the deficient practice is: No specific resident is mentioned. No corrective action could be completed. b) All patients have the potential of being affected. c) The immediate measures and systemic changes put into place to assure that the deficient practice does not recur: Administrator copied the facility's Theft & Loss Policy and placed it in the Survey/Consumer Binder in the lobby on 07/27/11. Social Service Assistant reviewed policy at resident council on 08/19/11. Administrator also attended Resident Council on 08/19/11 and explained the policy and answered questions. Facility will continue to provide newly admitted residents with copies of the policy, review policy annually with residents, provide training to newly hired employees and review annually with all staff. d) The facility plans to monitor its performance to ensure corrections are achieved and sustained by: Social Service Director or designee will attend Resident Council monthly. Missing articles, including clothing will be brought for possible identification. Medical Records will complete new admission audits which will include checking for personal belongings inventory sheet. Administrator and/or designeewill check annually that required postings are present. Audits and QA monitoring	

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A 034	Continued From page 1 Based on observation and interview, the facility failed to post its theft and loss policy. During an 11:42 a.m., 7/27/11 facility tour, Director of Nursing 1 and Administrator were unable to locate a posted copy of the facility's theft and loss policy. In a concurrent interview, the Administrator stated, "It should be posted." Review of the facility's undated admission packet "Theft and Loss Prevention Program Requirements" document revealed, "A theft and loss program shall be implemented by...long-term health care facilities...The program shall include all of the following...posting of the facility's policy regarding theft and investigative procedures." In addition, an undated "Theft and Loss Policy and Procedure" stated, "The theft and loss policy and procedure shall be posted in the facility lobby."	A 034	will be brought to the Quality Assurance Committee for problem analysis, action planning, and additional monitoring needs as indicated. **Completion Date: 08/19/11** **A179-72313(a)(2)** a) The corrective action to be accomplished for the patient identified to have been affected by the deficient practice is: Resident discharged on 07/14/11. No corrective action could be completed for this resident. b) All patients have the potential of being affected. During November, 2011 Medication Administration Record (MAR) recapitulation (recaps), licensed nurses corrected any missing parameters by notifying physicans and obtaining completed order. Completed by 12/01/11. c) The immediate measures and systemic changes put into place to assure that the deficient practice does not recur: On 12/13/11, Director of Nursing (DON) and Director of Staff Development (DSD), conducted a licensed nurse in-service which included vital sign parameters, when to hold medications, contact physician and notify physician of any vital signs not within stated parameters. This inservice included blood pressures. Following physician notification, licensed nurse will wait for further physician instructions. Inservice included facility's change of condition policy. d) The facility plans to monitor its performance to ensure corrections are achieved and sustained by: Licensed Nurses will perform shift to shift MAR checks; DON and/or designee and DSD will perform spot checks on MARs. Monthly recaps will include checking and correcting physican orders without acceptable parameters. DON and/or designee will review new physician orders during facility clinical meeting. Corrections will be noted and given to licensed nurse for physician clarification and follow up. Any trends will be brought to the Quality Assurance Committee for problem analysis, action planning, and additional monitoring needs as indicated. **Completion Date: 12/31/11**	
A 179	T22 DIV5 CH3 ART3-72313(a)(2) Nursing Service--Administration of Medication (a) Medications and treatments shall be administered as follows: (2) Medications and treatments shall be administered as prescribed. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to follow a physician order when Patient 1	A 179		

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A 179	Continued From page 2 received an antihypertensive (medication to lower blood pressure) medication when her blood pressure did not meet the minimum pressure for administering the drug. Patient 1 was an 84 year-old with a history of hypertension (high blood pressure). Medical record review revealed 6/25/11 physician orders as follows: Apresoline, 50 milligrams every 8 hours for hypertension. Hold if systolic (blood pressure at the time the heart is contracting, top number in a blood pressure reading) blood pressure is less than 110; Coreg, 12.5 milligrams bid (twice daily) for hypertension. Hold if systolic blood pressure is less than 110; Zestril, 20 milligrams daily for hypertension. Hold if systolic blood pressure is less than 110. Review of medication administration records revealed that Lisinopril was given at 9 a.m., 7/1/11 when Patient 1's systolic blood pressure was 95. Coreg and Lisinopril were given at 9 a.m., 7/3/11 when her systolic blood pressure was 108. Coreg was given at 5 p.m., 7/13/11 when Patient 1's systolic blood pressure was 104. In a 2:34 p.m., 12/7/11 interview, DON 2 concurred that these medications were administered when the systolic blood pressure was less than 110.	A 179	**A832-72523 (C) (2) (d)** a) The corrective action to be accomplished for the patient identified to have been affected by the deficient practice is: Resident discharged on 07/14/11. No corrective action could be completed for this resident. b) All patients have the potential of being affected. During November, 2011 Medication Administration Record (MAR) recapitulation (recaps), licensed nurses corrected any missing parameters by notifying physicans and obtaining completed order. Completed by 12/01/11. c) The immediate measures and systemic changes put into place to assure that the deficient practice does not recur: On 12/13/11, Director of Nursing (DON) and Director of Staff Development (DSD), conducted a licensed nurse in-service which included vital sign parameters, when to hold medications, contact physician and notify physician of any vital signs not within stated parameters. This inservice included blood pressures. Following physician notification, licensed nurse will wait for further physician instructions. Inservice included facility's change of condition policy. d) The facility plans to monitor its performance to ensure corrections are achieved and sustained by: Licensed Nurses will perform shift to shift MAR checks; DON and/or designee and DSD will perform spot checks on MARs. Monthly recaps will include checking and correcting physican orders without acceptable parameters. DON and/or designee will review new physician orders during facility clinical meeting. Corrections will be noted and given to licensed nurse for physician clarification and follow up. Any trends will be brought to the Quality Assurance Committee for problem analysis, action planning, and additional monitoring needs as indicated.	
A 832	T22 DIV5 CH3 ART5-72523(c)(2)(D) Patient Care Policies and Procedures (c) Each facility shall establish and implement policies and procedures, including but not limited to:	A 832	**Completion Date: 12/31/11**	

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A 832	Continued From page 3 (2) Nursing services policies and procedures which include: (D) Notification of physician regarding sudden or marked adverse change in a patient's condition. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to document physician notification when Patient 1's blood pressure fell to an abnormally low level. Patient 1 was an 84 year-old admitted from a general acute care hospital with diagnoses including high blood pressure and cerebral ischemia (insufficient blood flow to the brain). Upon admission at 4:30 p.m., 6/24/11, her blood pressure was measured at 124/62. Physician orders on admission included the following medications and parameters for administration: Apresoline, 50 milligrams every 8 hours for hypertension. Hold if systolic (blood pressure at the time the heart is contracting, top number in a blood pressure reading) blood pressure is less than 110; Coreg, 12.5 milligrams bid (twice daily) for hypertension. Hold if systolic blood pressure is less than 110; Zestril, 20 milligrams daily for hypertension. Hold if systolic blood pressure is less than 110. Record review revealed Patient 1's blood pressure during her stay ranged from a high of 178/78 (7 a.m., 6/26/11) to a low of 73/47 (9 p.m., 7.7.11). Patient 1's systolic blood pressure was less than 110 on 33 occasions. Five times her	A 832		

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A 832	Continued From page 4 systolic blood pressure was in the 80's. Her final blood pressure taken at 1 p.m.,7/14/11 on the day of discharge, was 77/41. In a 2:34 p.m., 12/7/11 interview with DON 2, she stated, "I can't find documentation that the doctor was notified [regarding the episodes of low blood pressure.]" The facility's 2010 "Managing Change of Condition Clinical Practice Guidelines" did not specify which clinical changes should be communicated to the physician.	A 832	**A1249-72649(b)** a) The corrective action to be accomplished for the patient identified to have been affected by the deficient practice is: No specific resident is mentioned. No corrective action could be completed. b) All patients have the potential of being affected. c) The immediate measures and systemic changes put into place to assure that the deficient practice does not recur: Director of Nurses (DON) immediately put oxygen tank in closet and properly secured the tank. d) The facility plans to monitor its performance to ensure corrections are achieved and sustained by: DON was aware that oxygen tanks must be stored in a secured position. Environmental rounds are completed quarterly by Maintenance Supervisor and/or designee. Oxygen storage is checked. Audits and QA monitoring will be brought to the Quality Assurance Committee for problem analysis, action planning, and additional monitoring needs as indicated. **Completion Date: 07/27/11**	
A1249	T22 DIV5 CH3 ART6-72649(b) Gases for Medical Use (b) Provision shall be made for safe handling and storage of medical gas cylinders. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to adequately safeguard oxygen cylinders when two were observed unsecured. During a facility visit at 11:19 a.m., 7/27/11, an oxygen cylinder was observed lying on its side on the floor of Director of Nursing 1's (DON's) office. A second was observed unsecured and standing upright in a storage room labeled "O2 [oxygen] Storage" between patient rooms 3 and 5. DON 1 placed the second cylinder into a storage rack. When asked if the cylinder in her office was empty, DON 1 stated she was "unsure." Review of the undated facility document "Oxygen and Cylinder Procedures" revealed, "Pressurized oxygen cylinders...become dangerous if	A1249		

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A1249	Continued From page 5 mishandled. If the cylinder is knocked over and the valve assembly breaks, the cylinder will become a missile or violently spin thereby causing damage to the entire room and the people within...."	A1249		