DEPAR

POC accepted. Spoke with administrator. 9/22/11@0930A

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TMENT OF HE	EALTH AND	HUMAN SERV	ICES			

PRINTED: 09/06/2011 FORM APPROVED

	ERS FOR MEDICARE & MEDICAID SERVICES  ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  OF CORRECTION IDENTIFICATION NUMBER:		(XZ) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
						COMPL		
055750		B, WING			OR/	C 24/2011		
NAME OF	PROVIDER OR SUPPLIER		<del></del>	STRE	ET ADDRESS, CITY, STATE, ZIP COD		C-WEU()	
AMBER	WOOD GARDENS			160	1 PETERSEN AVENUE N JOSE, CA. 95129	-		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	<u></u> _ <u>_</u>		PROVIDER'S PLAN OF CORE	ECTION	(35)	
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFO	<b>₹</b>	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)		GOMPLETION DATE	
F 000	INITIAL COMMENTS		F O	00	This POC is not an agree the facility as to the valid	-		
	The following refle	cts the findings of the		ł	element of the listed defi		1	
	; California Departm	ent of Public Health during a			This document is intende	ed as a		
	⊹ complaint investiga - 8/24/11.	tion conducted on 8/18/11 and			Plan of Correction to the DPH as			
					required by law. This pl			
	For Complaint CA00279918 regarding Admission, Transfer & Discharge Rights, Federal deficiencies were identified (see F203 and F204).		•		correction constitutes a written credible allegation of compliance		<b> </b>	
					for the deficiencies noted			
		ted to the one side corruption	_		overall Substantial Com	pliance	Įį.	
	Inspection was limited to the specific complaint investigated and does not represent the findings		Cai	iro;	with the Regulations.			
	of a full inspection of			**	with the Regulations.  REC HEALTH		1	
	: : Representing the C	alifornia Department of Public	S	EP.	TE AND		7/23/11	
ļ	Health was 29258,	Health Facilities Evaluator	La	- ام	2 PO2011		112.37	
E 203	Nurse:    483 12/5\/4\-/6\ NC	TICE REQUIREMENTS	E 2	XW.	The hacility shall comply	with the		
SS=0	BEFORE TRANSF	ER/DISCHARGE	1 41	<b>~</b>	TIOMAG SANGTANIAN DATOS.	•	[]	
		isfers or discharges a must notify the resident and,			shall and did notify the res family member or legal	auent,	:	
1	if known, a family m	nember or legal representative			representative of the reque	ested	<b>1</b> :	
		e transfer or discharge and move in writing and in a			discharge or transfer and t			
1		ner they understand; record			for the action in writing ar	ıd		
		esident's clinical record; and			document same in the reco			
	paragraph (a)(6) of	the items described in this section.			including the items of para	agraph	ļ	
	` <del></del>	ind in the common to CPN in the in-		ļ	(a)(6).			
}		ied in paragraph (a)(5)(ii) of ice of transfer or discharge		-	The facility thru the DSD	shall	n e	
	required under para	graph (a)(4) of this section			provide an in-service to th			
. ]		e facility at least 30 days is transferred or discharged.			Bookkeeping and Social S			
	: : 12016 010 15314611	e reneren er er dechalden.			staff with reference to the			
		e as soon as practicable			ensure that the place of pro-	oposed		
<u>_</u> <u></u>		scharge when the health of						
	M DIDECTOR® OF COOK	EDISUBPLIER REPRESENTATIVES SIGN	ATURE		TITLE		(Xe) DATE	

Any deficiency setement ending with an asterisk (\*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguents provide synicient 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 programs participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:MVTT11

Facility ID; CAD70000096

## PRINTED: 09/06/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 055750 08/24/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1601 PETERSEN AVENUE** AMBERWOOD GARDENS **SAN JOSE, CA 95129** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ΙĐ (X5)(X4) ID COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) This POC is not an agreement by F 000 INITIAL COMMENTS F 000 the facility as to the validly of any OF DIR. DEPARTMENT The following reflects the findings of the OF PUBLIC HEALTH his document is intended as a California Department of Fuoisconducted on 8/18/11 and EP 22 20California Department of Public Health during a Plan of Correction to the DPH as required by law. This plan of L&C DIVISION For Complaint CA00279918 regarding Admission, SAN JOSE correction constitutes a written credible allegation of compliance Transfer & Discharge Rights, Federal deficiencies were identified (see F203 and F204). for the deficiencies noted and overall Substantial Compliance Inspection was limited to the specific complaint with the Regulations. investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public F 203 9/23/11 Health was 29258, Health Facilities Evaluator Nurse The Facility shall comply with the F 203 ; 483.12(a)(4)-(6) NOTICE REQUIREMENTS F 203 notice requirements before **BEFORE TRANSFER/DISCHARGE** SS=D transfer/discharge. The facility Before a facility transfers or discharges a shall and did notify the resident, resident, the facility must notify the resident and, family member or legal if known, a family member or legal representative representative of the requested of the resident of the transfer or discharge and discharge or transfer and the reason the reasons for the move in writing and in a for the action in writing and language and manner they understand; record the reasons in the resident's clinical record; and document same in the record include in the notice the items described in including the items of paragraph paragraph (a)(6) of this section. (a)(6). Except when specified in paragraph (a)(5)(ii) of

IER REPRESENTATIVE'S SIGNATURE

this section, the notice of transfer or discharge required under paragraph (a)(4) of this section

must be made by the facility at least 30 days

Notice may be made as soon as practicable before transfer of discharge when the health of

before the resident is transferred or discharged.

Busentus Drector

The facility thru the DSD shall

Bookkeeping and Social Service

staff with reference to the need to ensure that the place of proposed

provide an in-service to the

(X6) DATE 9/20/11

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguages 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.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 055750 08/24/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1601 PETERSEN AVENUE AMBERWOOD GARDENS **SAN JOSE, CA 95129** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) discharge is clear and contains an F 203 F 203 Continued From page 1 address or other appropriate individuals in the facility would be endangered indication of the location to be under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more discharged or transferred to. immediate transfer or discharge, under paragraph, (a)(2)(i) of this section; an immediate transfer or The Administrator shall be discharge is required by the resident's urgent responsible for ongoing monitoring medical needs, under paragraph (a)(2)(ii) of this for continuing compliance. This section; or a resident has not resided in the facility for 30 days. shall be accomplished by a review of any and all discharge notices. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer Should there be any issue it shall be or discharge; the effective date of transfer or discharge; the location to which the resident is referred to the QA team for transferred or discharged; a statement that the resolution. resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally III Individuals Act.

This REQUIREMENT is not met as evidenced

Based on observation, interview and record review, the facility failed to indicate the location to which a resident would be transferred, when one of one sampled resident (1) was to be discharged

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-0391		
STAJEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED			
		055750	B. Wil	4G	08/	24/2011		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1601 PETERSEN AVENUE SAN JOSE, CA 95129	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 203	Resident 1 had a didisorder (involuntar group of muscles).  The Minimum Data tool) dated 4/7/11 in and short memory pimpaired decision mindicated Resident from staff with his a including transfer all eating, dressing and A notification of Resident by the facility to 8/11/11, indicated the with no specific additional to the sent by the facility to 8/11/11, indicated the with no specific additional and interview activity assistant (A no family, and no here to be a service (SS) living locally, his Pucontact. We don't keep the think he has a home the buring record reviet facility policy and provide of a Transfer The resident, and/or the sident, and/or the sident and	agnoses including seizure y series of contractions of  Set (MDS, an assessment adicated, Resident 1 had long problem and moderately making. The same MDS also 1 required total assistance ctivities of daily living (ADLs) and ambulation (mobility), at hygiene.  Sident Transfer or Discharge of the Public Guardian dated me transfer location as "home" press.  on 8/24/11 at 8:30 a.m., the A) stated, that Resident 1 had ome.  on 8/24/11 at 9:45 a.m., the stated, "There was no family blic Guardian was the only now where he lived and I don't	F	203				

including the location to which the resident is

being transferred or discharged". F 204 483.12(a)(7) PREPARATION FOR

F 204

DUILITED, AGRECIOAA

PRINTED: 09/06/2011 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING a. WNG 055750 08/24/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1601 PETERSEN AVENUE AMBERWOOD GARDENS SAN JOSE, CA 95129 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (XS) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX DATE TAG DEFICIENCY F 204 F 204 Continued From page 3 F 204 9-23-1 The facility shall have preparation for SS=D SAFE/ORDERLY TRANSFER/DISCHRG a safe/orderly transfer/discharge. Amberwood Gardens shall provide A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly sufficient preparation and orientation transfer or discharge from the facility. to resident or their responsible party or conservator to ensure safe and orderly transfer or discharge from the This REQUIREMENT is not met as evidenced facility. by: Based on record review the facility failed to prepare a resident for discharge, when one of The resident was not discharged nor one sampled resident (1) clinical records did not was a discharge anticipated, thus no contain documentation about orientation for a plan was made under facility's safe transfer and discharge. Findings: policy. Resident 1 had a diagnoses including seizure disorder (involuntary series of contractions of The DSD will provide an in-service group of muscles). to the Social Service staff with reference to the planning requirement The Minimum Data Set (MDS, an assessment too!) dated 4/7/11 indicated Resident 1 had long and the facilities policy. and short memory problem and moderately Discussed Discussed Pladmos regarding impaired decision making. The same MDS also The Administrator shall be indicated Resident 1 was a total assist with his responsible for continuing monitoring activities of daily living (ADLs) including transfer and compliance. The by a review of and ambulation (mobility), eating, dressing and hygiene. any and all related documentation for any resident who is actually being A notification of Resident Transfer or Discharge discharged or transferred within the was sent by the facility to Resident 1's Public Guardian dated 8/11/11. regulations for same.

FORM CMS 2567(02-99) Previous Versions Obsolete

after 8/5/11.

During record review on 8/24/11 at 11:00 a.m.,

. Social Service Progress Notes last entry was

dated 8/5/11 and did not contain transfer and discharge information. No further documentation

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Facility ID: CA070000098

and resolution.

Any issue that may arise shall be

directed to the QA team for action

If continuation sheet Page 4 of 5

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055750  NAME OF PROVIDER OR SUPPLIER  AMBERWOOD GARDENS		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER					
		8. WH	₩		C 08/24/2011		
		STREET ADDRESS, CITY, STATE, 1601 PETERSEN AVENUE SAN JOSE, CA 95129					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	COMPLETION DATE
F 204	On 8/25/11, review "Orienting Resident Discharges" dated post-discharge plar resident prior to his This plan will be reand/or his or her fa	of facility policy and procedure ts to Transfers and	F	204			
		i i					