STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555625	A. BUILDING _____ B. WING _____	C 12/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA PARK REHABILITATION HOSPITAL	2850 SIERRA SUNRISE TERRACE CHICO, CA 95928

(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 an Abbreviated Standard Survey for complaint 313284. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Representing the Department: 29582, HFEN and 15419, HFES. Complaint 313284 was substantiated and written at F309.	F 000	As the current Administrator of California Park Rehabilitation Hospital, I will be the person responsible for overseeing the correction. The correction is complete as of ~~01/17/2013~~ 1/24/13. 1/24/13. per K. Garcia, admin. 1/29/13 **Preparation and/or execution of this plan of correction does not constitute admission by the provider or the truth of the facts set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the Health and Safety Code Section 1280 and C.F.R.**	1/24/13
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, facility policy, and record review, the facility failed to ensure Resident 1's skin was assessed weekly in accordance with her plan of care and the facility's Skin Assessment policy. The facility's failure to perform and document the findings of Resident 1's planned weekly skin assessments potentially delayed the recognition and treatment of impaired circulation to the resident's toes, which lead to the	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	1-17-2013

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555625	A. BUILDING _____ B. WING _____	C 12/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA PARK REHABILITATION HOSPITAL	2850 SIERRA SUNRISE TERRACE CHICO, CA 95928

(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 309	Continued From page 1 development of gangrene. Findings: A document titled, Skin Assessments, dated 11/1/2010, outline the facility's policy and five point procedure for conducting, documenting and communicating the findings of weekly skin assessments performed on all residents. Procedure 1 - directed Certified Nursing Assistants (CNAs) to inspect the resident's skin when providing showers and to document all bruises, discolorations, and redness noted on the CNA Skin Sheet. 2 - read, "Nursing will conduct skin rounds once a week to assess the skin of every resident from head to toe." 3 - identified pertinent information licensed nurses were to document on the body assessment form. This included the location of all pressure and non-pressure ulcers (bruises), to make note of any contributing factors that needed to be investigated, and that pictures may be taken at the discretion of the nurse. 4 - directed the nurse conducting skin rounds to record their findings in the appropriate log, and 5 - addressed the assessment and documentation of pressure ulcers. Resident 1 was admitted to the facility on 6/1/11 with diagnoses that included a fractured hip, heart disease treated with bypass surgery and a pacemaker, respiratory problems, and depression. At the time of admission Resident 1 had a pressure ulcer on her left heel and one on her coccyx. Resident 1's potenial for skin breakdown score was 17; indicating a moderate risk for developing skin breakdown/pressure	F 309	**F309** **483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** Resident 1 no longer resides at the facility. 5/2012 No other residents have been known to have been negatively impacted by refusing weekly skin assessments. 7/2012 Current residents who refuse weekly skin assessments have been educated to the risks of refusing skin assessments starting in July of 2012. Ongoing education will be provided at the time of their refusal. 7/2012 ongoing Nurses have been educated verbally by the Director of Nursing regarding the importance of skin assessments and shower sheets. Shower sheets will ensure each resident is inspected during their shower by a CNA and all skin related issues will be documented at that time. A formal in service will take place on January 24, 2013. Moving forward, any residents who are refusing weekly skin assessments will be placed on a list by the nurse conducting weekly skin assessments and provided to the Director of Nursing. The Director of Nursing will review said list with the interdisciplinary team and will make every attempt to utilize alternative means of conducting skin assessments. 1/24/13 clarification on date per M. Morris 1-7-13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555625	A. BUILDING _____ B. WING _____	C 12/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA PARK REHABILITATION HOSPITAL	2850 SIERRA SUNRISE TERRACE CHICO, CA 95928

(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 309	Continued From page 2 ulcers. On 7/3/11 Resident 1 was transferred to the hospital and treated for pnuemonia and a urinary tract infection. Resident 1 returned to the facility on 7/12/11. The inital nursing assessment (Resident Data Collection), and the pressure ulcer and potential for skin intergirty care plans identified that Resident 1 had a pressure ulcer on her left heel and that her risk for skin breakdown had increased from moderate to high. The Minimum Data Set (MDS - a resident assessment tool), dated 2/16/12, described Resident 1 as cognitively intact, able to made her self understood, and that she was her own responsible party. She needed extensive assistance with bed mobility, transfers, dressing, toileting and bathing. The "Potential for Skin Integrity Interdisciplinary Care Plan," dated 7/12/11, directed staff to do weekly skin evaluations and daily skin checks during care. Nurse's note entries documented that Resident 1 began refusing weekly skin assessments on 8/26/11. She continued to refuse skin assessments; four times in 9/2011 (9/2, 9/9, 9/15 and 9/22), three times in 10/2011 (10/6, 10/14 and 10/28), three times in 11/2011 (11/11, 11/17 and 11/24), and on 12/2/11. On 12/8/11, Resident 1's care plan was updated to include her frequent refusal of full body weekly skin assessment by a nurse. However, the planned intervention, to have a Certified Nurses Assistants (CNAs) assess the resident's skin during her shower, was not new, it was the first step in the facility's policy and procedure for weekly skin assessments. Resident 1 continued to refuse weekly skin assessment, 13 times during the next 14 weeks (12/9/11 - 4/5/12). There was no documentation of a review or	F 309	Policies and procedures for skin assessments were reviewed and updated on 7-1-2012. Random audits will be conducted by the DON and DSD to ensure compliance and initiate interventions as well as updating the plan of care for residents who continually refuse weekly skin assessments. The quality assurance committee will continue to assess interventions to ensure resident needs are met. All negative findings will be reported to the administrator and the director of nursing and will be reviewed with the interdisciplinary team and quality assurance committee.	7/1/12 ongoing ongoing ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555625	A. BUILDING _____ B. WING _____	C 12/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA PARK REHABILITATION HOSPITAL	2850 SIERRA SUNRISE TERRACE CHICO, CA 95928

(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 309	Continued From page 3	F 309		

revision to Resident 1's care plan to ensure planned weekly skin assessments were accomplished in accordance with the resident's assessed needs, plan of care, and facility policy.

The nurse's note dated 4/5/12 at 7:25 pm, read, "Resident complained of 10/10 pain to left foot. Left foot slipper removed. Resident yelled out in pain. Resident's left foot 2nd, 3rd and 4th toes with dark purple discoloration. Anterior 2nd, 3rd toes red with slight swelling appearance."

On 6/21/12 at 1 pm, Treatment Nurse (TN) A stated that she wrote the above entry on 4/5/12. TN A stated, Resident 1 complained of pain in her left foot. I removed her left slipper and found the resident's 2nd, 3rd and 4th toes had dark purple discoloration. TN A confirmed that it was the facilities policy for the treatment nurse to do weekly skin assessments on residents. TN A stated that Resident 1 frequently refused to allow skin assessments, and that she documented the refusals in the resident's record.

An x-ray of Resident 1's left foot, obtained on 4/6/12, showed that Resident 1 had "a probable old fracture of the 2nd toe, a bone spur on her heel, and osteoporosis."

The nurse's note dated 4/6/12 at 8 pm, included documentation of a referral to a wound center for evaluation of Resident 1's "left foot 2nd, 3rd, and 4th toes - areas are necrotic and [Resident 1] complains of intolerable pain to light touch."

Resident 1's first visit to the wound center occurred on 4/13/12. The initial assessment described arterial ulcers; one on the distal portion

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555625	A. BUILDING _____ B. WING _____	C 12/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA PARK REHABILITATION HOSPITAL	2850 SIERRA SUNRISE TERRACE CHICO, CA 95928

(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 309	Continued From page 4	F 309		

of Resident 1's second toe that measured 1x1.5 cm with 76-100% eschar (dead tissue), and another on the medial portion of her 3rd toe that measured 0.5x0.7x0.1 cm that had a scant amount of serous drainage with 76-100% slough.

On 4/20/12, a test to assess the condition of blood vessels and blood flow to Resident 1's legs (a CT aortogram and bilateral lower extremity runoff) showed multiple areas of vascular disease that resulted in impaired circulation in her left lower leg.

On 6/26/12 at 09:15 am, the DON confirmed that Resident 1's had a diagnosis of gangrene; a term used to describe the decay or death of tissue caused by a lack of blood supply, in the toes of her left foot. The DON stated that she knew that Resident 1 refused to allow weekly skin assessments.

During an interview on 8/14/12 at 11:30 am, the DON and administrator stated that Resident 1 was her own responsible party, and as such, had the right to refuse weekly skin assessments. When asked how the facility ensures all resident's received the same quality of care in accordance with their assessed needs and facility policy, the DON explained that CNAs inspect the resident's skin during shower, however, the facility was unable to provide documentation of the CNA inspections. The DON and administrator were unable to provide documentation regarding the condition of Resident 1's left foot prior to 4/5/12 when she complained of extreme (10/10) pain.

The facility's failure to perform and document the findings of Resident 1's planned weekly skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555625	A. BUILDING _____ B. WING _____	C 12/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA PARK REHABILITATION HOSPITAL	2850 SIERRA SUNRISE TERRACE CHICO, CA 95928

(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 309	Continued From page 5 assessments potentially delayed the recognition and treatment of impaired circulation to the resident's toes, which lead to the development of gangrene.	F 309		