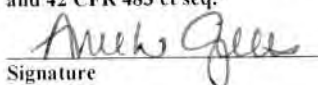
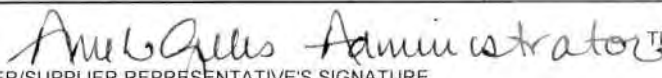


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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA230000030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/01/2011
NAME OF PROVIDER OR SUPPLIER WINDSOR REDDING CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2490 COURT STREET REDDING, CA 96001		
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A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of two entity reported incidents. Entity reported incidents: 290859 and 290876. The inspection was limited to the specific entity reported incidents investigated and does not represent the findings of a full inspection of the facility. Representing the Department: 29539, HFEN Three deficiencies were written for entity reported incident 290859 at A0165, A0197, and A0822. Three deficiencies were written for entity reported incident 290876 at A0165, A0822, and A0880.	A 000	"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 conclusions 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 Health and Safety Code Section 1280 and 42 CFR 483 et seq."  Signature A165 72311(a)(1)(C) Nursing Service - General <u>Corrective Action for Resident(s) Affected:</u> The affected residents 1,2 have had their care plans updated to reflect education on smoking and the smoking policy of the facility. Resident 3 has had care plan changes to reflect the potential for abusive behavior. Resident 2 is no longer a resident in the facility. <u>Identification of Residents with the Potential to be Affected:</u> All residents have the potential to be affected by potential abuse. The smokers have been identified and the staff are aware of who they are so they can be redirected to smoking areas and smoking times. <u>Measures to Prevent Recurrence:</u> The licensed nursing staff have been educated on initiating care plan and the policy and procedures of "Smoking" and "Resident to Resident Abuse". Education on abuse has been given on 11/15/11, 12/02/11, 12/13/11, 12/14/11, 2/16/12. Education will also be presented on 3/8/12 & 3/21/12. Smoking residents are reminded at every resident council of the smoking policy and the times for smoking are on all activity calendars. Calendars are posted in every resident room. Families, residents and significant others are informed during the admission process of the smoking policy, families are asked not to bring smoking materials directly to the resident. <u>Monitoring Corrective Action and Responsibility:</u> Random audits of care plans and will be done by the Medical Records Designee. Administrator responsible to ensure follow up takes place.	
A 165	T22 DIV5 CH3 ART3-72311(a)(1)(C) Nursing Service--General (a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (C) Reviewing, evaluating and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to update and reevaluate: 1. Patients 1 and 2's smoking care plans when they both had obtained cigarettes and matches and were discovered smoking unsupervised.	A 165		

3/23/12

Licensing and Certification Division

 Administrator TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

RECEIVED 3/19/12

(X6) DATE

STATE FORM

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If continuation sheet 1 of 10

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A 165	<p>Continued From page 1</p> <p>2. Patient 3's care plan to prevent further abuse to her roommates. This had the potential for Patients 1 and 2 to be injured from smoking and for the continued abuse to other patients by Patient 3.</p> <p>Findings:</p> <p>1. Patient 1 was admitted on 10/10/11 for Hospice (end of life) care for lung disease. Patient 1 was her own responsible party.</p> <p>Patient 2 was admitted on 9/13/11 with diagnoses that included chronic lung disease. Her son was her responsible party.</p> <p>On 11/30/11, Patient 1 and 2's records were reviewed. Nursing Note documentation in both records revealed that on 11/23/11, Patient's 1 and 2 were found outside in the smoking area at 7:45 am, smoking unsupervised and not wearing smoking aprons (prevents burns).</p> <p>On 11/30/11 at 10 am, during an interview, Patient 1 stated that she was outside smoking unsupervised at 7:45 am on 11/23/11. Patient 1 stated that she had obtained cigarettes and matches from a "visitor", and had not worn a smoking apron.</p> <p>On 11/30/11 at 10:30 am, Patient 2 stated during an interview, that she had a couple of cigarettes and a lighter, "on me," so she took herself out to smoke at 7:45 am on 11/23/11. Patient 2 stated that she was unsupervised and had not worn a smoking apron.</p> <p>On 11/30/11, Patient 1 and Patient 2's "smoking" care plans were reviewed. Patient 1's smoking care plan had been initiated on 10/21/11, and had</p>	A 165			

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A 165	<p>Continued From page 2</p> <p>not been updated to reflect that she had obtained cigarettes, matches, and was found smoking unsupervised, and without a smoking apron.</p> <p>Patient 2's "smoking" care plan had been initiated on 11/28/11, and had not been updated to reflect that she had obtained cigarettes, a lighter, and was found smoking unsupervised and without a smoking apron.</p> <p>On 11/30/11, the facility's policy titled, "Smoking Policy", dated 6/16/08, directed that:</p> <ol style="list-style-type: none"> 1. "Residents and responsible party will be informed of the smoking policy upon admission... 3. Smoking is allowed only in the designated area and only during scheduled times... 5. An employee is assigned to supervise smoking to ensure safety during smoking hours... 6. Residents are not permitted to keep smoking materials, lighters, matches or any other related items in their possession... 7. Residents requesting to smoke will be required to wear a smoking apron designated to retard combustion." <p>On 11/30/11 at 3:30 pm, during an interview and concurrent record review, Registered Nurse (RN) B stated that when she discovered Patients 1 and 2 outside in the smoking area at 7:45 am on 11/23/11, she reminded both of them that the first "smoke break" was not scheduled until 9 am, reeducated both of them on the facility's smoking policy, and then confiscated their cigarettes and matches. RN B confirmed that Patient 1 and 2's smoking care plans had not been updated or reevaluated to identify that they were at risk for injury by smoking unsupervised.</p> <p>2. Patient 3 was admitted on 4/24/09 with diagnoses that included heart failure. Patient 3</p>	A 165			

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A 165	Continued From page 3 was her own responsible party. On 12/1/11, Patient 3's record was reviewed. Patient 3's "Abuse Investigation" report, dated 11/25/11, revealed that she had verbally abused and physically threatened her roommate with a walker. Upon further record review, documentation in the Interdisciplinary Team Notes, Social Service Notes, and Nurses Notes, revealed that Patient 3 had been abusive to all of her roommates since she was admitted. Patient 3 had seven episodes of altercations with her previous roommate over a two month period, from 8/18/11 to 10/20/11, and one recent altercation with her new roommate, on 11/25/11. Patient 3's care plan "#6" documented that, "she's a loner", "territorial over room", and "vocal about not wanting a roommate." Patient 3's care plan did not reflect that she had been abusive to her roommates in the past, and had not included interventions to prevent future abuse to her roommates. On 12/1/11 at 10:30 am, during an interview, Social Service Director X confirmed that Patient 3's care plan had not been updated to reflect that she had a history of provoking abuse and altercations with roommates, and that there were no interventions in place to prevent future occurrences.	A 165			
A 197	T22 DIV5 CH3 ART3-72315(b) Nursing Service-Patient Care (b) Each patient shall be treated as individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind.	A 197			

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A 197	<p>Continued From page 4</p> <p>This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to treat Patient 1 and Patient 2 with dignity and respect, when Licensed Nurse (LN) A told them that they would be "strip searched", for smoking materials.</p> <p>Findings:</p> <p>Patient 1 was admitted on 10/10/11 with diagnoses that included Hospice (end of life) care for lung disease. Patient 1 was her own responsible party.</p> <p>Patient 2 was admitted on 9/13/11 with diagnoses that included chronic lung disease. Patient 2's son was her responsible party.</p> <p>On 11/30/11 at 10am, Patient 1 was observed and interviewed. Patient 1 stated that on 11/23/11 about 7:45 am, both she and Patient 2 had been outside smoking unsupervised and not during a designated smoking time. Patient 1 stated that when LN A had discovered that she and Patient 2 were smoking, LN A demanded that they both hand over their cigarettes and matches willingly or, "I will have to strip search you." Patient 1 was observed to be crying during the interview. Patient 1 stated she thought LN A was serious and, "I bawled my head off."</p> <p>On 11/30/11 at 10:30 am, Patient 2 was interviewed. Patient 2 confirmed that she and Patient 1 were smoking together unsupervised at 7:45 am on 11/23/11. Patient 2 stated that LN A approached her in the smoking area and informed her that it was not time to smoke and demanded that Patient 2 give LN A her cigarettes and lighter. LN A then stated, "You don't want me</p>	A 197	<p>A197 T22 Div 5 72315(b) Nursing Services Patient Care</p> <p><u>Corrective Action for Resident(s) Affected:</u> The affected patients 1, 2, and 3 have had care plans updated and revised to reflect current conditions. Resident 2 is no longer a resident in the facility.</p> <p><u>Identification of Residents with the Potential to be Affected:</u> All residents have the potential to be affected by the issue alleged in the statement of deficiency.</p> <p><u>Measures to Prevent Recurrence:</u> Licensed Staff have been re-educated on the Smoking Policy and the Abuse policy. Separating residents who are having conflicts is always a priority their individual rights and preferences are honored within the limits of safety. Education occurred on 2/22/12 and will occur again on 3/8/12 & 3/21/12 Smoking times are posted at the nursing station and on all activity calendars in the facility. Each resident has a calendar posted in their closet.</p> <p><u>Monitoring Corrective Action and Responsibility:</u> Any occurrences of abuse will be handled immediately by the charge nurse and will be brought forward to administration through the 24 hour report policy and will be discussed at Stand Up Meeting for further follow-up and investigation. Trends will be reported to the QA&A committee for follow up and recommendation... Administrator responsible to ensure follow up takes place.</p>		

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A 197	Continued From page 5 to strip search you do you?" Patient 2 was observed crying during the interview. Patient 2 stated, "I used to work in a jail, and that scared me, I believed [LN A] was going to strip search me and I felt very scared and degraded." On 11/30/11 at 1 pm, LN A was interviewed. LN A stated that when she had discovered Patient's 1 and 2 smoking unsupervised, on 11/23/11, she was "joking" when she threatened to "strip search" them. LN A stated that it became apparent to her that neither Patient 1 or Patient 2 had thought that her comment was funny, and they both began to cry. LN A stated, "I knew at that point it wasn't the best choice of words to use."	A 197			
A 822	T22 DIV5 CH3 ART5-72523(a) Patient Care Policies and Procedures (a) Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement their "Smoking" and "Resident to Resident Abuse" policies when: 1. The patient smoking times were not posted throughout the facility. 2. Patient 3 was not separated from Patient 2, after verbally abusing and physically threatening Patient 2. This had the potential for the patients not to be informed of when they were allowed to smoke, and for patients to suffer continued abuse, by not removing the aggressor.	A 822			

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A 822	<p>Continued From page 6</p> <p>Findings:</p> <p>1. On 11/30/11, the facility's policy titled, "Smoking Policy", dated 1/14/11, was reviewed. Procedure number four of the "Smoking Policy" directed that the, "Smoking schedule will be discussed with the residents and posted throughout the facility."</p> <p>On 11/30/11 at 9 am, an observation and concurrent interview with Administrative Staff (Admin) C, was conducted. The smoking schedule was not observed to be posted anywhere in the facility. Admin C confirmed that the facility's smoking schedule had not been posted throughout the facility, and that the "Smoking Policy" had not been followed.</p> <p>2. On 12/1/11, the facility's policy titled, "Resident to Resident Abuse", dated 12/06, was reviewed. In the abuse policy implementation section, number two directed that, "Should a resident be observed/accused of abusing another resident, our facility will implement the following actions:</p> <p>a. Remove the aggressor from the situation if the aggressor is still in the area in which the incident occurred;</p> <p>b. Temporarily separate the resident from other residents as a therapeutic intervention...;"</p> <p>On 12/1/11 at 9:30 am, Licensed Nurse (LN) M was interviewed. LN M stated that when Patient 3 had verbally abused and physically threatened Patient 2 in their shared room on 11/25/11, Patient 3 was not removed from the room because, "she was out of control, refused to be moved, and would have beat the hell out of us." LN M confirmed that the facility's abuse policy had not been implemented.</p>	A 822	<p>72523(a) Patient Care –Policies and Procedures</p> <p><u>Corrective Action for Resident(s) Affected:</u> The affected patients 1, 2, and 3 have had care plans updated and revised to reflect current conditions. Resident 2 is no longer a resident in the facility.</p> <p><u>Identification of Residents with the Potential to be Affected:</u> All residents have the potential to be affected by the issue alleged in the statement of deficiency.</p> <p><u>Measures to Prevent Recurrence:</u> The licensed nursing staff have been educated regarding the initiating of a care plans and the updating of the care plan. They have been educated on the Smoking Policy and the Resident to Resident abuse policy. Separating residents who are having conflicts is always a priority their individual rights and preferences are honored within the limits of safety. Education occurred on 3/8/12 and will occur again on 3/21/12 Smoking times are posted at the nursing station and on all activity calendars in the facility. Each resident has a calendar posted in their closet.</p> <p><u>Monitoring Corrective Action and Responsibility:</u> Random audits of the care plans will be done by the Medical Records Designee. The results of audits will be brought to the QA&A committee for follow up and recommendation. Administrator responsible to ensure follow up takes place.</p>	3/23/12

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A 880	Continued From page 7	A 880			
A 880	<p>T22 DIV5 CH3 ART5-72527(a)(9) Patients' Rights</p> <p>(a) Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated. The facility shall establish and implement written policies and procedures which include these rights and shall make a copy of these policies available to the patient and to any representative of the patient. The policies shall be accessible to the public upon request. Patients shall have the right:</p> <p>(9) To be free from mental and physical abuse.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to protect Patient 2's right to be free from mental and physical abuse. Upon admission, the facility placed Patient 2 in a room with Patient 3, who had a known history of being abusive to her roommates. As a result, Patient 2 was verbally abused and physically threatened to be hit with a walker, by Patient 3.</p> <p>Findings:</p> <p>Patient 2 was admitted to the facility on 11/20/11 with diagnoses that included lung disease.</p> <p>Patient 3 was admitted to the facility on 4/24/09 with diagnoses that included heart failure. The Minimum Data Set, an assessment tool, dated 10/9/11, reflected that Patient 3 was alert and oriented.</p>	A 880	<p>A880 72527(a)(9) Patients Rights <u>Corrective Action for Resident(s) Affected:</u> Resident 3 has been reviewed by the IDT and the plan of care has been revised. Resident 2 is no longer a resident in the facility.</p> <p><u>Identification of Residents with the Potential to be Affected:</u> All residents have the potential to be affected by the issue alleged in the statement of deficiency.</p> <p><u>Measures to Prevent Recurrence:</u> Licensed Staff have been re-educated on the Resident to Resident Abuse policy. Separating residents who are having conflicts is always a priority their individual rights and preferences are honored within the limits of safety. Education occurred on 2/22/12/ and will occur again on 3/8/12 & 3/21/12. Resident 3 will be monitored by the IDT for any reoccurrence of behavior which may affect others and revisions to the plan of care will be made as needed.</p> <p><u>Monitoring Corrective Action and Responsibility:</u> Any occurrences of resident to resident abuse will be handled immediately by the charge nurse and nursing staff and will be brought forward to administration through the 24 hour report process and will be discussed at Stand Up Meeting for further follow-up and investigation. Trends will be reported to the QA&A committee for follow up and recommendation... Administrator responsible to ensure follow up takes place.</p>		

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A 880	<p>Continued From page 8</p> <p>On 11/30/11 at 10:30 am, during an interview with Patient 2, she stated that on the evening of 11/25/11, she was in her bed and talking long distance on her cell phone. Suddenly, Patient 3 began screaming at her to get off of the phone, and picked up her walker and threatened to hit her with it. Patient 2 stated that Patient 3 scared her, so she yelled for help.</p> <p>On 11/30/11, a review of Patient 3's record was conducted. The Interdisciplinary Progress Notes contained documentation that Patient 3 had poured water on, yelled at, physically threatened, and had angry outbursts toward her previous roommates. The Social Service Notes contained documentation that Patient 3, "has had problems with every roommate she has had", and that when Patient 3 had been offered room changes and alternate placements, she refused. The Resident Care Conference Review notes, contained documentation that Patient 3, "doesn't like having roommates" and "doesn't do well with roommates." Patient 3's care plan "#6" documented that, "she's a loner", "territorial over room", and "vocal about not wanting a roommate." Meanwhile, the facility continued to place other patients in her room.</p> <p>On 12/1/11, an "Abuse Investigation" report dated 11/25/11, that involved Patients 2 and 3, was reviewed. The report contained documentation that Patient 2 had been "screamed" at by Patient 3 when Patient 2 was on the phone. Patient 3 then picked up her walker and threatened to "hurt" Patient 2, which caused Patient 2, "emotional upset and fear."</p> <p>On 12/1/11 at 4 pm, Administrative Staff (Admin) C was interviewed. Admin C confirmed that the</p>	A 880			

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A 880	Continued From page 9 facility was aware that Patient 3 had been abusive to her roommates. Admin C stated, "what are we supposed to do with her [Patient 3]?" Admin C confirmed that the interventions to prevent Patient 3 from abusing her roommates had not been effective, and that the facility had not ensured Patient 2's right to be free from abuse.	A 880			

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