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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES		2/20/10/	FORM APPROV	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0	39
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY	•
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED	
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		056378	B. WING_		05/13/2016	,
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		_
				3850 E. ESTHER ST.		
REGENC	CY OAKS POST ACUT	E CARE CENTER	1	LONG BEACH, CA 90804		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	FION (75)	_
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU	JLD BE COMPLÉTI	101
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F 000	INITIAL COMMENT	S	.F 000)		
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	The following reflect	ts the findings of the				
	California Departme	ent of Public Health during the				
	investigation of a co	mplaint.		<u>;</u>		
			j	·		
	Complaint number:	CA00484808 Substantiated				
	Donassantina the D	onestment of Dublin Health.				•
	Evaluator #36202 F	epartment of Public Health:				
	Evaluator #30202 F	1761				
	The inspection was	limited to the specific		This plan of correction constitutes the fac-	cility's	
		ated and does not represent		written credible allegation of compli	ance.	
		inspection of the facility.		Correction does not constitute admission		
		•		agreement by the provider of the truth of	of the	
İ		written as a result of entity		facts alleged or the conclusion set forth of Statement of Deficiencies. This ple	in the	
	reported incidents: (correction is prepared and/or executed	sclely	
F 329		GIMEN IS FREE FROM	F 329	because required by the provisions of	f the	
SS=E	UNNECESSARY DI	RUGS		health and safety code section 1280 ar	ld 42	
Į	~ 11.1 A1 1			0117.400.		
		regimen must be free from				
		An unnecessary drug is any excessive dose (including			J,	
		or for excessive duration; or			23]=_	
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		e; or in the presence of		273		
		ces which indicate the dose		m		
		or discontinued: or any		 ကို		

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

combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically

HAdministrator 7-1-11

In 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 ollowing 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 lays 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.

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Event ID: PSZ\$11

Facility ID: CA940000023

If continuation sheet Page 1 of 5

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PRINTED: 06/23/2016 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 SÜRVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 056378 B. WING 05/13/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3850 E. ESTHER ST. REGENCY OAKS POST ACUTE CARE CENTER LONG BEACH, CA 90804 SUMMARY STATEMENT OF DEFICIENCIES (XA) ID PROVIDER'S PLAN OF CORRECTION. (X8) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 329 Continued From page 1 F 329 contraindicated, in an effort to discontinue these drugs. F Tag identifier: F 329 Immediate corrective action(s) for those Residents affected by the deficient practice: This REQUIREMENT is not met as evidenced Resident was discharged 07/06/2015 Completion Based on interview and record review, the facility Date:6/30/16 failed to ensure that one of one sampled resident Plan/Process to Identify other residents (Resident 1) was free from unnessary drug. potentially affected by the same deficient Resident 1 was receiving Pristiq (anti-depressant) practice and corrective action(s) to be taken: and Quetiapine (antipsychotic medication to treat Residents receiving psychotropic medications mental illness and for behavior control) without have the potential to be affected. adequate indication. This deficient practice resulted in Resident 1 RN Supervisors/designee completed a facility receiving unnecessary drugs and placed the chart audit between 5/16/16-5/20/16 to Identify residents receiving psychotropics who were due resident at risk for side effect. for a gradual dose reduction and reviewed for those medications that were given without Findings: adequate indications. There were no other residents affected by the deficient practice. A review of record indicated Resident 1 was Licensed Nursing staff of three shifts was admitted to the facility on 4/13/15 with diagnoses Inserviced by the DON on 5/16/16 & 6/24/16 including unsteady gait, right hip fracture (broken regarding importance of gradual dose hip bone), dementia (decline in reasoning and reductions as well as the importance of giving memory), End Stage Renal Disease (ESRDmedications with adequate indications. kidney no longer functioning). Licensed Nursing staff of all three shifts was inserviced by contracted Pharmacy Consultant A review of Admission Minimum Data Set (MDSon 6/27/16 regarding time frame of gradual dose reductions and the importance of giving standardized assessment and care planning tool) medications with an adequate indication. dated 4/20/15 indicated Resident 1 was assessed as able to make self-understood and was able to Interdisciplinary Team was also inserviced by understand others. Resident 1 was assessed with the administrator regarding Gradual Dose

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no evidence psychosis and no behavioral

symptoms exhibited. Resident 1 requires extensive assistance (resident involve in activity, staff provide weight bearing support) with

locomotion on and off unit and with dressing, and

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Facility ID: CA940000023

Meetings on 5/16/16.

If continuation sheet Page 2 of 5

Reduction and Behavioral Management

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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00,10,2010
REGEN	CY OAKS POST ACUT	E CARE CENTER		3850 E. ESTHER ST. LONG BEACH, CA 90804	
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behavioral problem.

A review of Weekly Progress Notes dated 5/20/15, 5/27/15, 6/3/15 and 6/10/15 indicated no

The Interdisciplinary Team Notes (IDT) dated 7/2/15 indicated no documented evidence that

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Facility ID: CA940000023

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medications that need proper or adequate

indications are followed.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/23/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB</u> NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 056378 **B. WING** 05/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3850 E. ESTHER ST. REGENCY OAKS POST ACUTE CARE CENTER LONG BEACH, CA 90804 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DAT CROSS-REFERENCED TO THE APPROPRIATE DAT DATE DEFICIENCY) F 329 Continued From page 3 F 329 the Resident 1 was assessed for the risk and benefits of continue use of Pristiq and Quetiapine. There were no physician progress notes indicating that the Resident 1 will benefit for continue use of Pristiq and Quetiapine and or contraindication on tapering or discontinue of the antipsychotic drugs. Facility plan to monitor corrective actions and sustain compliance; Integrate QA An interview with the Registered Nurse (RN 1) on Process: 4/29/16 at 2:10 p.m., RN 1 stated that there was A quality-assurance program /Behavioral no psychiatric consult because there was no Management Committee Implemented under physician's order and the resident will only be the supervision of the Director of Nursing to referred if necessary. RN 1 stated "we don't have monitor residents for unnecessary medications IDT meeting for Resident 1's psychotropic with no adequate indication or gradual dose reduction. The Director of Nurse or designee medications". RN 1 stated that the facility conduct will perform the systemic change of auditing or an IDT for gradual reduction, and for Resident 1 monitoring of resident's physician's orders for they did not conduct an IDT meeting regarding psychotherapy medications. Audits schedule is the psychotropic drugs use because there were based new admission and when new order is no episodes of behavior observed and the iniliated. resident was stable with the psychotropic drugs. Any deficiencies will be corrected on the spot, RN 1 stated "there was no behavior it means and the findings of the quality-assurance she's stable and why discontinue". RN 1 stated checks will be documented and submitted to Resident 1 was monitored for bipolar disorder to the Monthly Quality Assurance and Performance Improvement Meetings for further manifested by hallucination for Quetiapine use review or corrective action. and she was not sure what kind of hallucination behavior the facility was observing for Resident 1. Completion Date:6/30/16 On 5/4/16 at 9:20 a.m. an interview with the Director of Nursing (DON) via telephone, the DON stated that there was no IDT meeting

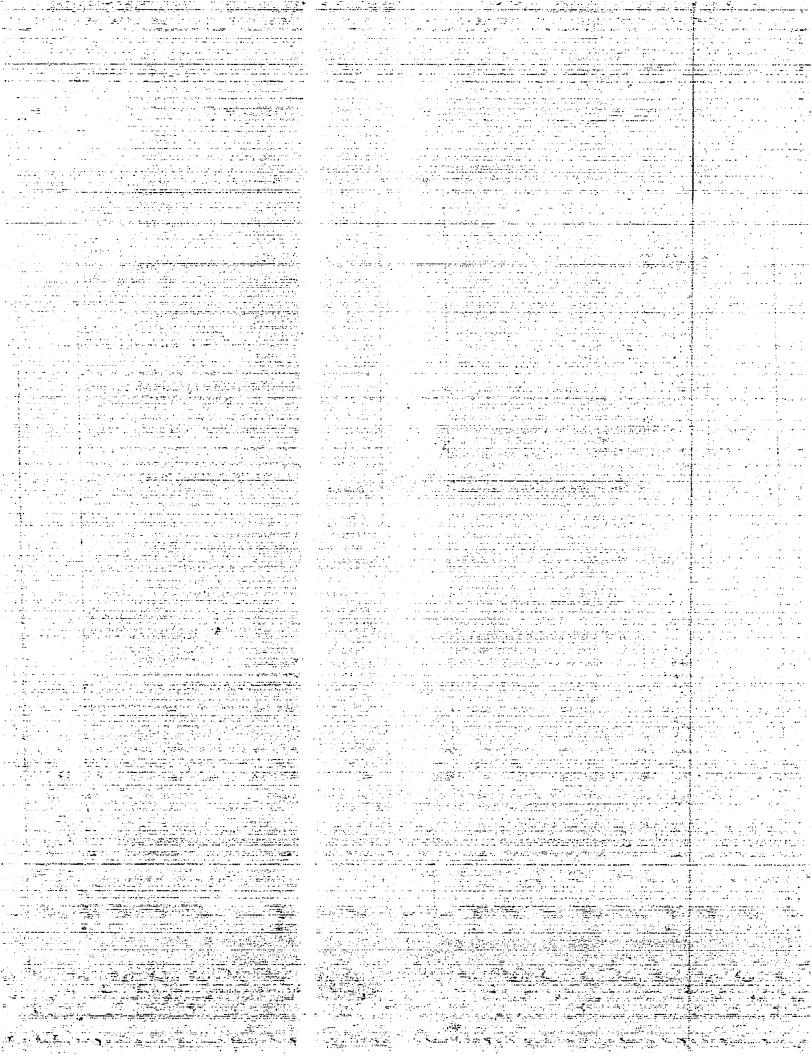
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regarding psychotropic drugs use and Resident 1 was stable. The DON stated that the resident was admitted to the facility with psychotropic

A review of facility's policy and procedures titled, "Antipsychotic Medication Use" dated February 2014, indicated, residents who are admitted from

Facility ID: CA940000023

If continuation sheet Page 4 of 5



CENTE	RS FOR MEDICARE	AND HUMAN SERVICES MEDICAID SERVICES	\$ S		FOR	D: 06/23/201
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A (X2) MÜLT	(X2) MULTIPLE CONSTRUCTION A BUILDING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	5/13/2016
REGEN	CY OAKS POST ACUT			3850 E. ESTHER ST. LONG BEACH, CA 90804	•	
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F 329	the community or tra who are already recomedications will be a appropriateness and interdisciplinary team of the psychotic medication and or with MDS assessment) to medication can be re discontinued. (c) Bas resident's symptoms Physician will determ	ansferred from a hospital a eiving antipsychotic evaluated for the I indications for use. The n will: (b) Re-evaluate the dication at the time of thin two weeks (at the initical consider whether or not	use al the			

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