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

PRINTED: 05/01/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055201	A. BUILDING _____ B. WING _____	C 04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER - HY-PANA	4545 SHELLEY COURT STOCKTON, CA 95207

(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 survey for the investigation of two (2) facility reported incidents #CA00560255 and CA00568428. Representing the Department of Public Health: HFEN, 32525 HFEN, 38528 HFEN, 31463 The inspection was limited to the specific facility reported incidents investigated and does not represent the findings of a full inspection of the facility. The Department was unable to substantiate a violation of the regulations for facility reported incident #CA00568428.	F 000	Golden Living Center – Hy-pana submits this response and Plan of Correction as part of the requirements under State and Federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements; it shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at anytime the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceeding on that basis.	
F 502 SS=D	ADMINISTRATION CFR(s): 483.50(a)(1) (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure outside radiological services were provided in a timely manner for 1 of 3 sampled residents (Resident 1) when a STAT (abbreviation used to indicate 'immediate') X-Ray was not completed until the following day.	F 502	**F 502 Administration** a) Resident 1 was assessed by charge nurse on 11/07/2017 and an x-ray was completed on 11/08/2018.	

5/11/18 POC Accepted Rashunda Hines

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Teresa Montero	Administrator	5/9/2018

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.

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F 502	Continued From page 1 This failure placed Resident 1 at risk for delayed interventions and pain due to a right femur (thigh) fracture. Findings: The facility Admission Record for Resident 1 indicated Resident 1 had been admitted to the facility in March 2017 with multiple diagnoses. The most recent quarterly assessment indicated Resident 1 scored 15 out of 15 in a Brief Interview for Mental Status (BIMS) which indicated he was cognitively intact. During an onsite visit on 11/17/17 at 2 p.m., Resident 1 was observed and interviewed briefly in his room before he left the facility for a scheduled appointment. Resident 1 stated his right leg was broken but had been fixed at the hospital a few days ago. Resident 1 was unable to recall the date he had complained of pain or when the X-Ray, which revealed he had a fracture, was completed. A review of a physician telephone order, dated 11/7/17 and timed at 10:54 a.m., indicated, "Stat Right hip x-ray for Pain 10/10 (numerical pain scale rating with 0 indicating no pain and 10 indicating extreme pain). Review of a radiological order form, dated 11/7/17, indicated the STAT X-ray was called in to the radiological company at 12:20 p.m. A nurses' progress note, dated 11/7/17 at 22:06 (10:06 p.m.) and labeled late entry, indicated, "At around 2100 (9 p.m.), writer called lab to f/u (follow up) stat x-ray. Spoke to (name) who	F 502	b) Medical Records Director (MRD) conducted an audit of all residents who had a fall for the month of April and May to ensure that any STAT x-ray orders received were completed in a timely manner. No other residents were identified with the same deficient practice. c) In-service was conducted by DSD on 05/08/2018 to Licensed Nurses in regards to facility procedure of STAT x-ray orders and the timeframe they should be completed in. Administrator and DON will be notified by licensed nurse of any resident who has an order for STAT x-ray and will validate if the order was completed timely. DON will check during the five days Clinical Start up for review and validation, during the weekend the RN Supervisor will check, review and validate. Issues identified will be corrected immediately by LN and a report will be submitted to the Administrator during the five days Department Managers meeting for review, validation and immediate resolution. Additional training and education will be conducted by DSD during orientation and annually to all licensed nurses.	

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F 502	Continued From page 2 stated that tech lab would be coming at anytime..." Review of the radiological report indicated the date of service for Resident 1's X-ray was provided on 11/8/17 at 10:15 a.m. A review of the facility's hospital transfer form indicated Resident 1 was sent to the hospital on 11/8/17 at 11:20 a.m., over 24 hours after the physician order for a STAT X-ray. During an interview with the facility Administrator on 11/17/17 at 3:30 p.m., when asked how soon should a STAT X-ray for Resident 1 have taken, she indicated immediately. The administrator validated the radiological services for Resident 1 were not completed in a timely manner. A policy on timeliness of radiological services was requested from the administrator on 12/13/17 at 8:10 a.m. and she stated the facility had none.	F 502	**d)** DON will monitor facility compliance by checking during the five days Clinical Start up for review and validation, during the weekend the RN Supervisor will check, review and validate, non compliance issues identified will be corrected immediately by LN and a report will be submitted to the Administrator during the five days Department Managers meeting for review, validation and immediate resolution. MRD will monitor facility compliance by conducting an audit two times a week, non compliance issues identified will be submitted to the DON for review and immediate resolution. Additional training and education will be conducted by DSD during orientation and annually to all licensed nurses. DON and/or MRD will do trending/analysis and will report to the quarterly QAPI Committee for further evaluation and/or recommendations. 5/14/18	