PRINTED: 08/19/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 055201 B. WING 08/17/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4545 SHELLEY COURT GOLDEN LIVING CENTER - HY-PANA STOCKTON, CA 95207 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY Preparation, submission and F 000 INITIAL COMMENTS F 000 implementation of this Plan of Correction does not constitute an The following reflects the findings of the admission of or agreement with the California Department of Public Health during an abbreviated standard survey for the investigation facts and conclusions set forth on of an entity reported incident #CA00360740. the survey report. Our Plan of Correction is prepared and executed Representing the Department: as a means to continuously improve HFEN 32525 the quality of care and to comply **HFEN 31979** with all applicable state and federal Inspection was limited to the specific incident regulatory requirements. investigated and does not represent the findings of a full inspection of the facility. This Plan of Correction constitutes 483.25(I) DRUG REGIMEN IS FREE FROM F 329 F 329 my written credible allegation of UNNECESSARY DRUGS SS=D compliance for the deficiency Each resident's drug regimen must be free from noted. unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including 483.25 (1) Drug Regimen is Free duplicate therapy); or for excessive duration; or From Unnecessary Drugs without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose 1. Corrective action(s) should be reduced or discontinued; or any accomplished for the patient combinations of the reasons above. identified to have been affected by the deficient practice. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not For the resident identified 7/20/13 given these drugs unless antipsychotic drug monitoring form for behavioral 8/8/13 therapy is necessary to treat a specific condition manifestations and adverse effects as diagnosed and documented in the clinical record; and residents who use antipsychotic was put in place July 20, 2013 and a drugs receive gradual dose reductions, and care plan was initiated for the use of behavioral interventions, unless clinically the medication, on August 8, 2013. contraindicated, in an effort to discontinue these (see attached copies) drugs.

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

TITLE

(X6) DATE

STORY

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.

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: 055201	A BUILDING		(X3) DATE SURVEY COMPLETED C 08/17/2013	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 1545 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)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	DBE	(X5) COMPLETION DATE
F 329	Continued From page 1		F 329	 How other patients having the potential to be affected by the same deficient practice be identified and what corrective action will be taken. 		
	by. Based on staff in review, the facility manifestations, m and initiate care p the antipsychotic	terview, and clinical record failed to monitor behavioral conitor for adverse side effects clanning for Resident 1 for use of medication iloperidone. This tential to impact Resident's 1 ment outcomes.		An audit was completed by DN and ADNS for all residents wit psychotropic medications to ensthat monitoring form was in pla and there was a care plan for the medication. Corrective action tas appropriate.	th sure ace e	8/8/13
	with multiple diagratisorder, chronic disorder, chronic cirrhosis of the liviliver), hypertension diabetes mellitus way the body use. The most recent is standardized asset indicated that Residecision making with memory problems "Antipsychotic" medialipsychotic medialiness) 4 milligram behavior manifest	Minimum Data Set (MDS, a essment tool) dated 6/18/13 ident 1 was independent in with no long-term or short-term is, and was not receiving edications. Inical records on 7/18/13 an order for iloperidone (an ication used to treat mental is by mouth twice daily. The ations and adverse effects were ed. There was no care plan for		3. What immediate measures as systemic changes will be put in place to ensure the deficient practice does not recur. Inservices was conducted for licensed staff covering entering psychotropic medication orders informed consent verification, printing of behavior and side af monitoring form and advising Social Service for adding or updating information in for the Behavioral Management Committee. (Summary Report of Meeting a attachments enclosed).	fects	7/19/13

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Event ID SVXD11

Facility ID: CA030000073

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER: 055201	(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 08/17/2013	
	PROVIDER OR SUPPLIE	R	4	TREET ADDRESS, CITY, STATE, ZIP CODE 545 SHELLEY COURT STOCKTON, CA 95207	00/1/12013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD IT TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		BE COMPLETION			
F 329	A review of the fact labeled "golden of Management Guid under medications drug is a drug who monitoringside of monitored" Page compliance indicated monitoring system behaviors, interve effectiveness and to follow their clinical management guid During an interview Nursing (ADON) of acknowledged the Resident 1's behave antipsychotic medication was or medication was	cility's document on 7/18/13 inical services -Behavior deline revised 2013", page 2 s reflected, "An unnecessary en used:without adequate effects of these drugs must be the 3 under monitoring ted "care plan developed A is established for targeted intions and medication side effects." The facility failed cal services behavior teline. w with the Assistant Director of the facility failed cal services behavior teline. w with the Assistant Director of the facility failed cal services behavior for 7/18/13 at 12:30 a.m., she there was no monitoring of viors or adverse effects of the fication iloperidone. There was initiated on 7/10/13 when the fidered by the physician. The fied, "The nurse might have	F 329	The Director of Nursing and IDT review daily using Golden Clinic Start up Checklist all new orders accuracy in medication and dosag diagnosis, and behavioral and adverse effect monitoring. 4. Description of the monitoring process and positions of persons responsible for monitoring. Behavioral Management Committee (Social Services, MD Coordinator, nursing representatives, and pharmacy consultant, on site or by phone) meet at least monthly to conduct interdisciplinary review, analysis and if warranted, revision or creation of a behavior management plan for both behavioral and pharmacological. (see attached description) Director of Nursing or designee will report monthly Quality Assurance and Assessment Committee, on any compliance issues with psychotropic medicat order entry, informed consent verification, behavior and adverse effect monitoring.	al for ge, Ongoing S an Ongoing Ongoing	

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

Event ID: SVXD11

Facility ID: CA030000073

If continuation sheet Page 3 of 3

