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

PRINTED: 10/11/2017
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
	555376	A. BUILDING _____ B. WING _____	C 09/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REHABILITATION	336 DIABLO ROAD DANVILLE, CA 94526

RECEIVED
OCT 26 2017
Licensing & Certification
East Bay District Office

(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 represents the findings of the California Department of Public Health during the investigation of an entity reported incident. Entity reported incident number: CA00550453 Representing the Department: Health Facilities Evaluator Nurse: 35388 The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for the entity reported incident: CA00550453	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. This plan of correction is prepared and/or executed solely because the provisions of Federal and State Law require it. This Plan of Correction is submitted as the facility's credible allegation of compliance.	
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 221	*F221* *483.10(e)(1)-(1), 483.12 (a)(2) Right to be Free From Physical Restraints* The facility maintains that the resident has a right to be treated with respect and dignity. It is the policy of the facility that residents have the right to be free from physical restraints. *How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:* An investigation was concluded on 08/31/17. A copy of the investigation was provided to CDPH and LTC Ombudsman. There was no adverse outcome to the resident. The Director of Social Services and Nursing Supervisor provided immediate education to the staff.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 10/26/17

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.

POC accepted 10/26/17 O.S

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F 221	Continued From page 1 treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to honor the rights of one (Resident 1) of three sampled residents to be free from physical restraint, when a sheet was used as a restraint for the convenience of staff, without a physician's order, nor a consent or care plan. This failure had the potential to cause loss of mobility and self esteem and to result in serious injury if Resident 1 slid down in the wheelchair or attempted to stand. Findings: During a review of the clinical record for Resident 1, the history and physical, dated 8/18/17, showed Resident 1 had diagnoses of urinary tract infection, difficulty in walking and dementia (decline in mental ability that interferes with daily functioning). A physician's note ,dated 8/22/17, showed Resident 1 did not have the capacity to make his own decisions. The care plan for Resident 1 showed he had a risk for falls. The interventions for fall prevention were a low bed, alarms for the bed and wheelchair and landing	F 221	*How the facility will identify other residents having the potential to be affected by the same deficient practice:* Other residents were interviewed to ensure no other residents were affected. There were no other residents affected. There was only a potential for other residents to be affected. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:* The Administrator, Director of Nursing, and Nursing Supervisor provided in-service training to staff. The Director of Nursing and/or designee will monitor licensed and certified nursing staff to ensure that residents are free from physical restraints. *How the facility plans to monitor its performance to make sure that solutions are sustained:* The facility Quality Assurance Performance Improvement (QAPI) indicator for F221 will be completed no less than quarterly. The QAPI indicator will be assigned by the Administrator to a designated staff member. The QAPI indicator outcomes will be reviewed and evaluated at the Quality Assurance meeting. The Management Practices Subcommittee, of the Quality Assurance Performance Improvement committee, shall review the indicator on a quarterly basis to ensure compliance.	

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F 221	Continued From page 2 pads on each side of his bed. A review of the nurse's Progress Notes for Resident 1, dated 8/26/17 at 10:24 p.m., showed Resident 1 was alert and verbally responsive with bouts of confusion. The Progress Note showed Resident 1 had attempted to get out of bed without assistance and he was placed in the wheelchair. During an interview on 9/7/17 at 10:10 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she arrived for her shift at 11:09 p.m. LVN 1 stated she saw Resident 1 sitting in a wheelchair with a sheet around his waist and tied in the back of the wheelchair. LVN 1 stated Resident 1 was a little bit agitated, but she spent time talking with him and he calmed down. LVN 1 asked the evening staff why Resident 1 was tied up and she untied the sheet. During an interview on 9/25/17 at 1:37 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 was very restless and trying to get out of bed the evening of 8/26/17. CNA 1 informed the nurse and was told to get him up in a wheelchair. CNA 1 stated she was afraid Resident 1 would try to stand up from the wheelchair so she tied a sheet around his waist and placed him sitting in the wheelchair at the nurse's station. CNA 1 stated then she went to care for her other residents. During an interview on 9/27/17 at 12:15 p.m. LVN 2, LVN 2 stated she cared for Resident 1 on the evening shift 8/26/17. LVN 2 stated she observed Resident 1 sitting in his wheelchair with a sheet across his waist and pulled through the area under the armrest of the wheelchair and tied in the back of the wheelchair. LVN 2 acknowledged the sheet was used as a physical restraint.	F 221	*Responsible:* Adminstrator, Director of Nursing, and staff. *Date of Completion:* September 1, 2017	

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F 221	Continued From page 3 During an observation on 9/7/17 at 11:40 a.m., Resident 1 was observed walking in the hall with a physical therapist. A pad alarm was observed in his wheelchair. Resident 1 was alert and cooperative with the therapist. A review of the facility's policy and procedure titled ,"Abuse Prevention," indicated facility residents should be free from physical abuse including unreasonable physical constraint.	F 221		