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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056391	A. BUILDING _____ B. WING _____	04/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN EMPIRE CONV HOSP	121 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 a Recertification Survey from 4/2/12 to 4/5/12. Representing the Department: HFEN's 27945, 28000, 22707, 29340, and 29721 Census: 132 Sample size: 24	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278	**F 278** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** *No negative outcome for the resident occurred. Action was immediately taken, resident has one hearing aide for the Left ear, but frequently refuses to wear it. The hearing aid is now locked in the med cart to maintain safety and be available should the resident request it.* **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** *All residents have the potential to be affected by the same deficient practice. The Care Plan will clearly state when a resident has hearing aids, what their status of hearing is like, and if they use other devices to communicate. Such as, a communication board, sign language, or reads lips.* **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia Juey acting administrator — TITLE — (X6) DATE: 4/23/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056391	A. BUILDING _____ B. WING _____	04/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN EMPIRE CONV HOSP	121 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 278	Continued From page 1 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the licensed nurses documented accurate assessments of Resident 19's hearing status in the weekly nursing summaries. For Resident 19, the facility's failure to assess and document the fact that she was deaf could cause a misunderstanding of information, diagnoses and/or treatments when relayed between Resident 19 and staff or physicians. Findings: Record review indicated that Resident 19 was 77 years old and admitted to the facility on 2/22/12. Diagnoses included infection in the blood, pneumonia, a Stage II pressure sore to the heel, and uncontrolled diabetes. During an observation and interview on 4/5/12 at 9:30 am, Resident 19 used American Sign Language (communication using the hands and fingers to form letters and words) to state that she was totally deaf in both ears and that she did not have hearing aids for either ear. Review of the weekly nursing summaries for Resident 19 showed that the assessments were not consistent from her admission summary, dated 2/29/12, through the most current nursing summary, dated 3/28/12. None of the	F 278	*All Licensed nurses will be in-serviced on how to correctly get the information they need to complete a weekly summary. Audits will be conducted by Medical Records to ensure the practice does not recur, and RN Care Managers will get a list of the audits to ensure that assessments are correctly entered in the medical record. Care Managers who have difficulty with any audits will bring them to the attention of the Director of Nursing* **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;** *Medical Records Audits for this will also go to the Director of Nursing who will be conducting inquiries to the Care Managers and compliance with the correction. The Director of Nursing will be bringing this to the attention of the QA committee should the deficiency action continue or start up again.* **Completion Date:** *May 30, 2012*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056391	A. BUILDING _____ B. WING _____	04/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN EMPIRE CONV HOSP	121 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 278	Continued From page 2 assessments for Resident 19 indicated that she was totally deaf. The first week summary indicated Resident 19 was hard of hearing. The following week, the nurse indicated there was no problem with her hearing. Then Resident 19 was assessed to be hard of hearing, and on two different weeks, nurses documented that the resident had a hearing aid in different ears. The weekly nursing summaries did not give an accurate picture of Resident 19's hearing status and a staff member or visiting physician would think Resident 19 was able to hear and understand what was said to her by what was documented, when she actually depended on a communication board, lip reading, and/or American Sign Language. During an observation of the facility's computerized charting system and interview on 4/5/12 at 8:50 am with Licensed Nurse G, she stated that the nursing weekly summaries were completed by the floor nurses, via the computer which offers available choices for answers. LN G stated that the nurse could type in other words or phrases for a more definitive description and demonstrated that she was able to type in the information that Resident 19 was totally deaf for an accurate entry, rather than use the computer box entries for the hearing assessment. During an interview on 4/5/12 at 9:15 am, a Supervisory Licensed Nurse (LN H) stated that the floor nurses should have been familiar with the residents they write the weekly summaries on, and the assessments/summaries should be consistent and accurate.	F 278		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056391	A. BUILDING _____ B. WING _____	04/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN EMPIRE CONV HOSP	121 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 312 SS=D	Continued From page 3 DEPENDENT RESIDENTS	F 312		

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to provide feeding assistance during the lunch meal in a timely manner to one of 24 sampled residents (Resident 21). This failure resulted in waiting for a meal while others were fed and tears of frustration from Resident 21 who indicated that he was hungry.

Findings:

Resident 21 was admitted to the facility on 7/3/10 with diagnoses that included Alzheimer's dementia, anxiety, and diabetes. The Minimum Data Set (MDS- an assessment form), dated 10/12/11, described Resident 21 as rarely or never being understood and progressively declining, both physically and mentally. For the eating activity, he required extensive assistance from one person to set up and prepare his tray, but was able to eat select "finger foods." Review of the Activity interview section of the MDS indicated that Resident 21 considered, "Most important: to have snacks between meals."

On 4/2/12 at 12:00 pm, Resident 21 was observed seated at table one in the dining room

F 312

How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

The facility will ensure that all residents get fed in a timely manner. Adequate staff will be available to provide assistance to residents requiring it at all mealtimes.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

All residents have the potential to be affected by this deficient practice. Care Managers will be monitoring meals and making sure there is adequate staff for all residents to be assisted as needed.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;

Care Managers will be monitoring meals and making sure there is adequate staff for all residents to be assisted as needed. CNA's who need extra assistance during a meal will notify the Care Manager of any potential problems. Director of Nursing, DSD and MDS teams will be doing random checks to make sure this is occurring.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056391	A. BUILDING _____ B. WING _____	04/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN EMPIRE CONV HOSP	121 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 312	Continued From page 4 in his wheelchair. Present at the table were three other Residents. Covered dining trays were placed in front of all four residents and remained covered for 10 minutes. Resident 21 was then wheeled out into the hallway, from where he was able to watch other residents being fed. Certified Nurse Assistant (CNA) F was interviewed on 4/2/12 at 12:13 pm, and questioned as to the reason Resident 21 was removed from the dining room. CNA F stated she was assigned to feed the other two residents at table one and a second CNA was assigned to feed Resident 21. CNA F stated she removed Resident 21 from the dining room so he would not have to watch the other residents being fed while he was required to wait to eat, as the CNA assigned to feed him was not in the dining room. Resident 21 was interviewed on 4/2/12 at 12:15 pm. He was unable to talk, but responded with facial gestures and nodding of his head. When Resident 21 was questioned as to how he felt when he was removed from the dining room, his eyes began to tear up. When questioned if he was hungry for his food, Resident 21 nodded his head up and down and began crying.	F 312	**How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;** *DSD, MDS, and Care Managers will be notifying the DON if any breakdown in the practice occurs. The Director of Nursing will notify the QA team if the practice is recurring to re-evaluate the POC and make corrections as necessary.* **Completion date:** *May 30, 2012*	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**F 371** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** *1. Dietary Supervisor immediately in-serviced staff that all tray carts are to be disinfected after each meal. Staff was also, in-serviced that if they open or touch anything that is not part of the tray line, and could be potentially dirty they are to change gloves.* *2. The food that was stored in the medication room was immediately removed. No food items will be stored in a medication room. All food items are to be dated when they are brought into the facility. All food items need to be inspected to make sure all lids are sealed or in a closed container/bag..*	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056391	A. BUILDING _____ B. WING _____	04/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN EMPIRE CONV HOSP	121 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 371	Continued From page 5	F 371		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure resident meals were prepared under sanitary conditions when two dietary staff were observed not changing gloves between tasks and preparing food. This failure had the potential to compromise the health status of residents who received meals. The facility also failed to ensure that opened and undated food items were not stored in a medication room. This failure had the potential for spoilage of the food items and attraction of pests in the medication room.

Findings:

1. On 4/3/12 at 11:15 am, during an observation of lunchtime meal preparation, Dietary Staff (DS) A used her gloved hands to open a door to a dish storage area, then proceeded to retrieve dishes, place them on the counter on the tray line and began filling plates with food. The touching of dirty surfaces and going directly to food preparation with no glove change observed in between tasks had the potential to spread bacteria and contaminate food and food surface areas.

On 4/3/12 at 11:30 am, DS B was observed placing his gloved hands on the outside of the food tray cart, a dirty surface, to push it towards the door for delivery to the dining room. DS B, without a glove change, proceeded to touch the handles of ladles, adding sauces to food plates.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

All residents have the potential to be affected by this deficient practice.
1. All dietary staff were re-in-serviced on the glove policy of changing gloves between tasks, and that all tray carts are to be disinfected between meals.
2. All food items were taken out of the medication room and placed in the kitchenettes. All food items were checked to make sure they were dated.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;

1. Dietary Supervisor will be doing random rounds during the tray pass to make sure that all staff are adhering to the policy.
2. Assistant DSD will be inspecting medication rooms to make sure no food items are left in them, and following up on any deviation from the policy.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056391	A. BUILDING _____ B. WING _____	04/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN EMPIRE CONV HOSP	121 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 371	Continued From page 6 A review of an undated dietary services policy titled, "Glove Use Policy," indicated gloves needed to be changed before beginning a different task. During an interview on 4/3/12 at 12:30 pm, DS C stated that he was aware that the dietary staff should have changed gloves between touching storage area handles, tray carts, and prior to serving food. 2. An inspection of the medication storage room on the 100 Hall was completed on 4/3/12 at 2 pm with Licensed Nurse I (LN I). Two opened 16 ounce plastic jars of a resident's food snack, "Cherries, Berries, and Nuts," were observed on the bottom shelf on the right side of the room. One jar lid was not completely sealed and no opened dates were observed on the jars. The lack of opened dates on the jars and two of the same food item being opened could allow outdated food to be given to the resident. The jar lid not being completely closed could allow an increased spoilage time and/or the attraction of pests into the medication room. During a concurrent interview, LN I stated both opened jars belonged to the same resident on the 100 Hall. LN I stated she did not know that resident food items or supplements were not to be stored in the medication storage room, and confirmed the above findings.	F 371	**How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;** *The Dietary Supervisor and the Assistant DSD will bring any problem with non-compliance back to the QA meeting. If there is any problem a new plan will be in-acted and follow up to assure compliance.* **Completion date:** *May 30, 2012*	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465	**F 465** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** *No negative outcome for a resident occurred. The cardboard deflectors were immediately removed from the heating vents.*	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056391	A. BUILDING ______ B. WING ______	04/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN EMPIRE CONV HOSP	121 DORSEY DRIVE GRASS VALLEY, CA 95945

(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 465 Continued From page 7

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, the facility failed to maintain a safe and functional environment as seen by cardboard deflectors attached to the ceiling heater vents in Rooms 402B and 605B. This failure was a potential fire hazard.

Findings:

On 4/2/12 at 9:40 am, during initial tour, with Licensed Nurse D, the ceiling heater vents in Rooms 402B and 605B were observed to have a large piece of cardboard extending from the ceiling to the heater vent directly over each resident's beds. These rooms were occupied by four residents, two residents in each room.

During an interview with Maintenance Supervisor E on 4/4/12 at 11:30 am, he confirmed that the cardboard was placed on the two heater vents to deflect the air away from the residents in the "A" beds, and confirmed that this practice was a fire risk. He also stated that the original residents who complained about the heat, no longer occupied the "A" beds.

F 465

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

All residents had the potential to be affected by the same deficient practice. The maintenance supervisor immediately reset all the heating vents to change the amount of direct airflow that would come out of the heating vents.

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 maintenance supervisor immediately reset all the heating vents to change the amount of direct airflow that would come out of the heating vents. If this is not affective the company who services our heating system and vents will be making deflectors that will be appropriate for the heating vents we have in the facility.

How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

If there are any complaints from residents it will be brought to the QA team and the Maintenance Supervisor will contact the company that services our heating and vent system for further action on solving the problem.

Completion date:
May 30, 2012