STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055311	A. BUILDING _____ B. WING _____	08/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KATHERINE HEALTHCARE	315 ALAMEDA AVENUE SALINAS, CA 93901

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
OCT - 5 2012
L & C DIVISION SAN JOSE

(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 annual recertification survey conducted from 8/20/12 through 8/27/12. The facility was licensed for 51 beds. The census at the time of the survey was 42 residents. There were 11 sampled residents. Complaint CA00320908 regarding Quality of Care/Treatment was investigated during the survey and was unsubstantiated. Complaint CA00322130 regarding Quality of Care/Treatment Resident Abuse, Employee to Resident was investigated and deficiencies were identified (see F226 and F241). Representing the California Department of Public Health: 10918, Health Facilities Evaluator Nurse and 17536, Health Facilities Evaluator Nurse.	F 000	**DISCLAIMER CLAUSE** **PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.**	
F 164 SS=B	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the	F 164	**F 164 Personnel Privacy/Confidentiality of Records** **Residents affected:** **All resident's have the potential to be affected. The confidentiality Names List was removed by the Administrator immediately. The Administrator interviewed the resident who read the survey and saw the Confidential Names List. The Administrator told the resident that in the future the list of names will not be available for public viewing. The resident told the Administrator that she would check to be sure it's not included in the binder.**	

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
L & C DIVISION SAN JOSE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE Executive Director (X6) DATE 09/21/12

A[redacted]n 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

PRINTED: 09/06/2012
FORM APPROVED
OMB NO. 0938-0391

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CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
OCT - 3 2012
LICENSING & CERTIFICATION DIVISION

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F 164 SS=B	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the	F 164	**F 164 Personnel Privacy/Confidentiality of Records** 10/11/12 **Residents affected:** **All resident's have the potential to be affected. The confidentiality Names List was removed by the Administrator immediately. The Administrator interviewed the resident who read the survey and saw the Confidential Names List. The Administrator told the resident that in the future the list of names will not be available for public viewing. The resident told the Administrator that she would check to be sure it's not included in the binder.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rhonda V Degadon — TITLE: Executive Director — (X6) DATE: 09/21/12

...y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...llowing 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 ...ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ...rogram participation.

10/3/12 poc accepted - 2nd submission original + amended q19 being mailed - [redacted]

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F 164	Continued From page 1 release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain resident confidentiality when the Confidential Names List (CNL, list of Resident identifier with corresponding resident names) with the results of the most recent survey of the facility was available for public view. This failure created the potential of residents' personal and medical information to be viewable by residents, family and the public. Findings: During an environmental tour of the facility with the administrator present on 8/22/12 at 9:05 a.m., the results of the most recent facility survey, dated 7/17/11 and the CNL was in a binder, chained to a hallway near the facility entrance. The ADM then removed the CNL and stated the residents' confidential information was available to the pubic in error.	F 164	**Systemic changes:** **The Administrator will place the most current surveys in the Survey Binder available for public viewing. He will be quite vigilant to validate that the names list is not available for public viewing.** **Monitor:** **The Administrator will report to the CQI committee the month following insertion of the survey result into the binder that the names list was not included.** CALIFORNIA DEPARTMENT OF PUBLIC HEALTH OCT - 5 2012 L & C DIVISION SAN JOSE	

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F 164	Continued From page 2 During in an interview on 8/23/12 at 11:50 a.m., ADM stated the CNL and last year's survey result were posted last year. During an interview on 8/23/12 at 12 noon, Resident 12 stated she read the contents of the binder and noted the report mentioned her former roommate who passed away.	F 164	**F 226 Develop/Implement Abuse/Neglect, etc. Policies** **Resident affected:** **Resident 1 was interviewed by both Social Service Director (SSD) and Executive Director (ED) between the dates of 08/03/12 and 08/07/12 related to a malfunction of the hoyer lift while she was being transferred. During those multiple interviews resident did not tell either the SSD or the ED that she felt she had not been treated appropriately by the aide during the transfer nor did she indicate to either of these two staff members that an aide had failed to change her in a timely manner. Resident 1 has been re-interviewed and has indicated to Management Staff that she is not fearful of the hoyer lift transfers and there have been no further issues with not changing timely by aide mentioned or any other staff in how they are treated.**	10/11/12
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement their policy/procedure to report alleged rough handling and neglect to the State survey agency and the local Ombudsman in accordance with the facility's abuse prohibition policy when one of 11 sampled residents (1) told a physical therapy assistant (PTA) that certified nurse assistant A (CNA A) rough handled her during a transfer using the Hoyer lift and neglected to change her soiled disposable brief on 8/3/12. Findings: Resident 1's 6/27/12 Minimum Data Set (MDS, an assessment tool) indicated Resident 1 was moderately impaired in cognition, was totally dependent on at least two staff for transfers, toilet use, personal hygiene, and bathing, and was frequently incontinent of bowel and bladder. The	F 226		

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F 226	Continued From page 3 resident was alert and oriented to person, place and time. During an interview on 8/20/12 at 2:45 p.m. PTA stated Resident 1 told her on 8/3/12 CNA A treated her roughly when CNA A transferred her from her bed to her wheelchair, and CNA A ignored her request for a disposable brief change. PTA stated she told the staff developer and the social service director on 8/3/12 of Resident 1's allegation of rough handling and neglect. During an interview on 8/21/12 at 7:00 a.m. Resident 1 stated on 8/3/12 during the day shift, two certified nurse assistants (CNA A and B) transferred her from her bed to her wheelchair using a Hoyer lift (a battery powered device to lift a person). Resident 1 stated CNA A did not support her weak right leg which dropped during the transfer causing her discomfort. Resident 1 stated she asked CNA A to change her soiled disposable brief and CNA A told her she would return later to change it but never did. Resident 1 stated she had to ask the evening shift nurse assistant to change her disposable brief that was soiled with urine and feces. The PTA stated she did not report to the Ombudsman by telephone regarding Resident 1's allegations. The PTA stated she sent a written report on 8/10/12 at 2:20 p.m. by fax to the Ombudsman. The PTA stated she is a mandated reporter in terms of reporting abuse or neglect. The abuse Prohibition Manual dated February 2007, page 2 B1, indicated reporting to the facility ombudsman may be required per state	F 226	**How identify other residents having potential to be affected and corrective action taken:** **Executive Director (ED) and Social Service Director (SSD) have interviewed other residents to validate that there are no other residents with care and/or treatment by staff concerns that have been reported to ED or addressed appropriately by the Center.** **Systemic changes:** **The Centers Management Staff received in-servicing by the Regional Vice President (RVP) on the Centers policies and procedures related to prevention of abuse/neglect, protection, reporting, investigating requirements per Center policy, State and Federal regulations.** **The Staff Development Coordinator (DSD) provided in-service on 07/23/12 and 08/14/12.**	

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F 226	Continued From page 4 requirements. Welfare and Institutions Code, Section 15630(b)(1)(A) indicated any mandated reporter who in his or her professional capacity has knowledge of an incident that reasonably appears to be neglect shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible. If reported by telephone, a written report shall be sent within two working days, as follows: If the abuse has occurred in a long-term care facility, the report shall be made to the local ombudsperson or the local law enforcement agency. The facility failed to follow this state law. Record review and interview on 8/22/12 at 10:50 a.m. with the administrator indicated no staff reported Resident 1's allegations to the State survey agency, the California Department of Public Health (CDPH), District Office. The Abuse Prohibition Manual dated February 2007, page 2 B1, also indicated: Events involving allegations of abuse, neglect, mistreatment, misappropriation of resident property, or injuries of unknown source are reported immediately to the state survey and certification agency. The facility failed to implement this procedure.	F 226	**The DSD will continue to provide in-services to Center staff on abuse/neglect and mandatory reporting monthly for 3 months and then a minimum of quarterly thereafter.** **The ED and/or designee will quarterly utilize the Center's Quality Assurance (QA) tool to randomly interview staff on abuse/neglect and mandatory reporting.** **Monitor:** **The Executive Director will present findings of QA interviews on abuse/neglect and mandatory reporting with the development of action plans as appropriate to the monthly CQI committee.**	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	**F 241 Dignity and Respect of Individuality** **Residents affected:** **Resident 1 was re-interviewed and has indicated to**	10/11/12

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F 241	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of 11 sampled residents (1) was treated with dignity when certified nurse assistant A (CNA A) did not change the resident's soiled brief when the resident requested. Findings: Resident 1's 6/27/12 Minimum Data Set (MDS, an assessment tool) indicated Resident 1 was moderately impaired in cognition, was totally dependent on at least two staff for transfers, toilet use, personal hygiene, and bathing, and was frequently incontinent of bowel and bladder. Resident 1 was alert and oriented to person, place and time. Resident 1 described by staff as a reliable historian, had no documented history of fabricating stories and falsely accusing staff. During an interview on 8/21/12 at 7:00 a.m. Resident 1 stated on 8/3/12 during day shift she asked CNA A to change her soiled disposable brief and CNA A told her she would return later to change it but never did. Resident 1 stated she had to ask the evening shift nurse assistant to change her disposable brief that was soiled with urine and feces. When asked how she felt, Resident 1 stated she felt ashamed because CNA A treated her as if she was a burden and not one that needed help. Resident 1 stated she could not even ask staff to bring her to the toilet because the toilet was not flushing, and even if it was working, her wheelchair would not clear the doorway leading to	F 241	**Management Staff that there have been no further issues with aides not changing or providing other cares timely.** **How identify other residents having potential to be affected and corrective action taken:** **The Managers during daily rounds will ask random interviewable residents if there are any concerns related to care and services on delivery and how staff are treating them utilizing the QA tool. These will be reviewed at the morning stand up meeting.** **Systemic changes:** **The staff member who was identified by resident 1 relating to both the hoyer lift and not returning to provide care timely has been in-serviced. DSD did in-service nursing assistants on 08/04/12 and 08/17/12 on the hoyer lift and**	

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F 241	Continued From page 6 the toilet.	F 241	**on what constitutes abuse/neglect and treating residents with dignity. The DSD will provide in-service a minimum of once per quarter**	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medically related social services was provided to a resident who displayed mood problems. Findings: Resident 2's record was reviewed on 8/20/12. The Minimum Data Set (MDS, an assessment tool) dated 8/12/12 indicated Resident 2 had both short and long term memory problems, had moderate impairment in daily decision making skills and required one person staff assistance for activities of daily living, such as eating. The MDS dated 6/4/12 and 8/12/12 both indicated Resident 2's mood score was 8, indicating he had symptoms of feeling down and bad about oneself and having little interest or pleasure in doing things. In an observation on 8/20/12 at 7:50 a.m., Resident 2 was in the second floor dining room refusing breakfast. He twice asked a certified nurse assistant (CNA) that he return to bed. The Nutrition Evaluation/Progress Notes dated 8/2/12 indicated a staff member had described	F 250	**F 250 Provision of Medically Related Social Service** **Resident affected:** **Resident 2 no longer resides in the center.** **How identify other resident having potential to be affected and corrective action taken:** **Residents during their RAI if PHQ-9 (Patient Health Questionnaire) indicates symptoms of depression, the DSD will initiate further evaluation for depression and**	12/11/12

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F 250	Continued From page 7 Resident 2 appearing to be depressed. The wound center note dated 8/15/12 indicated Resident 2 had an appointment scheduled on 8/29/12 for possible further amputation of his right leg. The record did not address Resident 2's mood. There was no social services evaluation or progress note. During an interview on 8/23/12 at 10:30 a.m., the social services director stated when a resident returned from a hospital, a new social services evaluation that included assessment of mood status is conducted. Currently the facility did not have a tool to assess residents' mental and mood status. The SSD acknowledged a mood assessment was not performed for Resident 2.	F 250	**to center staff on residents rights with dignity presented at each in-service.** **The DSD will then provide in-services to center staff on abuse/neglect and mandatory reporting monthly for 3 months and then a minimum of quarterly thereafter. These in-services may be presented by both disciplines at the same time.** **Monitoring:** **The ED will be responsible to trend monthly the resident interviews done by managers and present to the monthly CQI committee with action plans as appropriate. The ED will be responsible to monitor for ongoing compliance.**	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide maintenance services to ensure one of 11 sampled residents (1) was able to use the toilet or commode for urination or defecation. Findings: Resident 1's 6/27/12 Minimum Data Set (MDS, an assessment tool) indicated Resident 1 was moderately impaired in cognition, was totally dependent on at least two staff for transfers, toilet use, personal hygiene, and bathing, and was frequently incontinent of bowel and bladder. The	F 253	**F 253 Housekeeping & Maintenance Services:** **Residents affected:** **The part necessary to repair the toilet was delivered to the plumbing company on**	10/11/12

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F 253	Continued From page 8 resident was alert and oriented to person, place and time. During the initial tour on 8/20/12 at 10:20 a.m. the toilet in Resident 1's room had a sign "out of order" on the toilet cover. The toilet would not flush when the toilet tank lever was pressed. It remained in this condition when observed on 8/22/12 at 3:00 p.m. During an interview on 8/20/12 at 10:20 a.m. certified nurse assistant B (CNA B) stated the toilet had not been flushing for the last two weeks. During an interview on 8/20/12 at 10:20 a.m. Resident 1 stated, with the toilet out of order, she had no other choice but to urinate and defecate in her disposable brief. On 8/27/12 at 8:00 a.m. the toilet had an "out of order" sign on the toilet cover. The sound of water flowing was heard as the toilet tank lever was pressed, but the contents of the bowl would not flush. During an interview on 8/27/12 at 8:15 a.m. Resident 1 stated staff offered her a bedpan, but still wanted her to eliminate waste in her disposable brief. Resident 1 stated she was not pleased with this suggestion. During an interview on 8/27/12 at 8:20 a.m. CNA B stated she had been the day shift nurse assistant assigned to Resident 1 from 8/20/12 through 8/27/12. After checking the toilet, CNA B stated there were sounds of running water, but the water would not flush down the toilet. CNA B	F 253	**08/28/12. The Maintenance Supervisor picked up the part and repaired the toilet on 08/28.12. The bathroom affected is a shared bathroom with private rooms on either side. Both of the residents in either room did not use to bathroom but each used a bedside commode.** **All residents have the potential to be affected when any item of equipment fails or requires repair.** **Systemic changes:** **Staff will be in-serviced by the Maintenance Supervisor and Executive Director on the use of the maintenance binder located at each nursing station. The Maintenance Supervisor will check the binder each morning and make any repairs necessary. The Maintenance Supervisor will record in the binder the date repairs were made. In addition, the Executive Director makes daily rounds and will record in the maintenance binder any repairs that need to me made.**	

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F 253	Continued From page 9 stated Resident 1 still defecated and urinated in her brief, and from her past experience caring for her, Resident 1 had not been brought to the toilet or commode.	F 253	**F 279 Develop Comprehensive Care Plans** **Residents affected:**	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure care plans were either developed or revised for two of 11 sampled residents (2 and 4). Resident 2, who was noncompliant with care, did not have a care plan developed. Also, Resident 2's wound and Resident 4's pressure ulcer care plans were not	F 279	**Resident 4's care plan was revised during the survey process. This resident is no longer residing in the center. Resident 2 no longer resides in the center.** **How identify other residents having potential to be affected and corrective action taken:** **The IDT team at a minimum during the scheduled RAI process will review, modify and update the residents care plans,**	10/11/12

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F 279	Continued From page 10 revised. Care plans identify resident concerns and outlines the care and services needed to meet their needs. Findings: 1. Resident 2's record was reviewed on 8/20/12. On 6/29/12, a wound culture result indicated his right leg wound was infected. The Minimum Data Set (MDS, an assessment tool) dated 8/12/12 indicated Resident 2 had short and long term memory problem, had moderate impairment in daily decision making skills and required one person staff assistance for activities of daily living, such as eating. In an observation on 8/20/12 at 7:50 a.m., Resident 2 was in the second floor dining room refusing breakfast. He twice asked a certified nurse assistant (CNA) that he return to bed. During an interview on 8/23/12 at 2:25 p.m., CNA D stated Resident 2 took off his bandage and touched his wound, sometimes daily. On 8/23/12 at 2:30 p.m., licensed nurse F (LN F) stated Resident 2 at times removed his dressing. The physical therapy notes dated 6/26/12 and 6/27/12 indicated Resident 2 refused to participate in physical therapy. On 6/28/12, the physical therapy discharge note indicated Resident 2 was not progressing in physical therapy. He had intermittent participation. On 7/5/12 at 2 p.m., nurses note indicated a CNA saw Resident 2 pull off his dressing. The record did not contain a care plan addressing Resident 2's behavior of noncompliance.	F 279	**Systemic changes:** **The DNS in-serviced on 09/05/12 Licensed Nurses (LN) on process for updating care plans as appropriate when there are changes in the residents health status and/or new orders received. Further in-services for LN on care planning are scheduled for 09/19/12 to be presented by the DNS. The DNS will monitor by randomly auditing a minimum of three residents charts weekly for accuracy and timely updates of care plans** **Monitoring:** **The Director of Nursing Services will trend audits and present to the CQI committee the findings and as appropriate action plans for maintaining ongoing compliance.**	

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F 279	Continued From page 11 Resident 2 also had a care plan developed for his surgical incision. The care plan was not revised to indicate the leg wound began having drainage and dehiscence (surgical complication in which a wound breaks open along the surgical suture). On 6/23/12 the wound became infected requiring antibiotics for treatment. The changes in treatment orders such as wound clinic recommendations on 8/1/12, 8/712 and 8/15/12 were not updated in the care plan. On 8/15/12, the wound clinic recommended a physician consult as soon as possible. During an interview on 8/23/12 at 11:50 a.m., the director of nurses (DON) who reviewed the record stated there was no care plan for noncompliance and the wound care plan was not updated. 2. Resident 4's record was reviewed on 8/23/12. Resident 4 was admitted to the facility with diagnoses including diabetes and a history of stroke and pressure ulcer. During observations on 8/20/12 at 2 p.m., 8/21/12 at 7:30 a.m., and 8/23/12 at 11 a.m., Resident 4 had a booty applied to her right heel. The 4/9/12 care plan for potential for skin integrity impairment did not indicate the use of a bootie as an approach. The 7/4/12 pressure ulcer care plan and 7/27/12 care plan addressing right foot/heel wound were not revised. For example, Resident 4 underwent debridement (removing nonliving tissue from pressure ulcers) and had a wound vacuum applied to her right heel. The care plan did not	F 279		

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F 279	Continued From page 12 clearly indicate when the wound was debrided and on what days the wound vacuum was in use. Also, the care plan did not specify when approaches were added and when changes in dressing treatment began and ended. In the same interview on 8/23/12 at 11:50 a.m. the DON stated Resident 4's pressure ulcer care plan was not revised.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to meet professional standards of quality when a physician's order for occupational therapy service to evaluate and treat a resident's contracted (tightening of muscle or tissue resulting in loss of joint motion) upper extremity was not carried out for one of 11 sampled residents (6). Findings: Record review on 8/22/12 indicated Resident 6 was admitted to the facility with diagnoses including a history of stroke and contractures. A Minimum Data Set (MDS, an assessment tool) dated 5/21/12 indicated Resident 6 had short and long term memory problems, severe impairment in daily decision making skills, and required extensive assistance for activities of daily living, such as eating. During observations on 8/20/12, 8/21/12 and	F 281	**F 281 Services provided meet Professional Standards..** **Resident's affected:** **Resident 6 has been seen by OT and fitted for splints on 08/23/12. Splints are now part of the resident's restorative program by nursing.** 10/11/12 **How identify other residents having potential to be affected and corrective action taken:** **Charge Nurses have reviewed charts to validate that there are no other resident with orders for therapy that were not communicated and carried out.** **Systemic changes:** **The DNS or designee will in-service LN on utilization of**	

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F 281	Continued From page 13 8/22/12, Resident 6 had stiffness to her left arm and hand and did not have a splint applied. The Rehabilitation Screening Form dated 6/8/12 indicated an occupational therapist (OT) noted Resident 6 presented with increased tone to her left elbow/hand/shoulder with "some contracture." A recommendation was then made to evaluate and treat for range of motion (ROM), provide splinting and contracture management. The same form also indicated a physician's order was obtained on 7/6/12 for the recommended OT service. In an interview on 8/23/12 at 12 noon, the occupational therapist (OT) stated when he was referred by nursing, he evaluated Resident 6 and made the recommendation. The OT did not know the physician had approved and signed the order and the "communication fell through." He stated the resident would have benefited from a hand splint to prevent fingers from curling into her palm.	F 281	**the "Rehabilitation Screening" form. The DNS or designee will review new telephone orders for therapy with the Rehab Manager at the daily stand up meeting. Medical Records will audit monthly that all new telephone orders for therapy have been communicated and implemented timely. The audit will be provided to the ED and DNS. Monitor: The DNS will trend the audit done by Medical Records and present findings to the CQI committee and action plans as appropriate to maintain compliance.**	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314	**F 314 Treatment and Services to Prevent/Heal Pressure Sores: Residents Affected:**	10/11/12

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F 314	Continued From page 14 by: Based on observation, interview and record review, the facility failed to ensure a resident who developed a heel pressure sore received care for one of 11 sampled residents (4). On 7/4/12 Resident 4 developed a pressure sore to her right heel. The initial wound assessment was not accurately assessed; preventative measures such as when a bootie was initiated was unclear; wound assessments were not documented on a weekly basis in accordance with facility policy and the pressure sore care plan was not updated. Findings: Resident 4's record was reviewed on 8/23/12. Resident 4 was admitted to the facility with diagnoses including diabetes and a history of stroke and pressure ulcer. The Minimum Data Set (MDS, an assessment tool) dated 6/1/12 indicated Resident 4 had short and long term memory problem, moderate difficulty in daily decision making skills, and required assistance for all activities of daily living, such as eating. During observations on 8/20/12 at 2 p.m., 8/21/12 at 7:30 a.m., and 8/23/12 at 11 a.m., Resident 4 wore a bootie on her right heel. During wound care observation on 8/23/12 at 11 a.m., Resident 4's right heel wound measured 9 cm by 8 cm. (centimeter, 1 inch is 2.54 cm). The depth of the wound was 1.5 cm at 6 o'clock, 0.7 at 7 o'clock, and 0.5 at 3 o'clock. Licensed nurse F (LN F) described the wound as infected and foul smelling with black eschar at 20% and slough of 30% (dead tissue). On 4/9/12 a care plan for potential for skin integrity impairment was developed. The care	F 314	**Resident 4 no longer resides in the center.** **How identify other residents having potential to be affected and corrective action taken:** **DNS and licensed nurses have completed a review of residents with skin integrity problems to validate that an appropriate treatment is in place for each resident and that the care plan is current to the actual problem being treated.** **Systemic changes:** **On 09/19/12 the DNS provided additional in-service to licensed nurses on pressure ulcer, prevention, identification, staging and treatment modalities. Care planning was also included as was notification of physician and responsible party. Scheduled for 09/24/12 is another in-service for LN on**	

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F 314	Continued From page 15 plan did not indicate the use of a bootie as an approach. The record lacked documentation indicating when the bootie was initiated as a preventative measure. A nurses note on 7/4/12 at 6 p.m. indicated Resident 4 had a new Stage 1 pressure sore to her right heel measuring 4 cm by 2 cm black area with erythema (redness) surrounding the blackened area measured 8 cm by 7 cm, no open area. Nurses note on 7/6/12 at 8 p.m. also described the right heel as Stage 1. A Stage 1 pressure sore is a pressure related alteration to intact skin with persistent redness. A 7/11/12 at 4 p.m. nurses note indicated the heel pressure ulcer was clarified with a physician as a deep tissue injury (DTI). A DTI is a purple or maroon localized area of discolored intact skin caused by damage to underlying soft tissue from pressure and/or shear. On 7/12/12 the licensed nurse wrote on a Physician's Progress Note form requesting a physician to look at Resident 4's right heel Stage 2 wound. A physician's order was obtained on 7/12/12 for a change in wound treatment order. On 7/4/12, Resident 4's heel wound on the Wound/Skin Evaluation and Documentation form was initiated. The form is an assessment tool that included pressure ulcer staging, description and size of wound and current treatment. The purpose of the form included to track the progression of the wound and to determine if physician notification was needed to revise interventions. There was no wound assessment documentation for 7/18/12 to 7/25/12.	F 314	**pressure ulcers and wound care to be presented by Consulting Certified Wound Nurse.** **The DNS will accompany the treatment nurse on weekly skin rounds for 3 weeks and then a minimum of 1 time per month to validate ongoing compliance with the center's Skin Program.** **Monitoring:** **The DNS will at the monthly CQI committee meeting provide a report on pressure ulcers, the action plans taken and any new actions developed to maintain on-going compliance with skin program.**	

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F 314	Continued From page 16 The August 2009 policy, "Skin Integrity Policy," directed nursing staff to complete a weekly skin inspection and to document on the Wound Evaluation and Documentation Form when a skin problem was identified and weekly thereafter until resolved. The 7/4/12 pressure ulcer care plan and 7/27/12 care plan addressing the right foot/heel wound were not revised. For example, Resident 4 underwent debridement (removing nonliving tissue from pressure ulcers) and had a wound vacuum (a medical device to aid healing) applied to her right heel. The care plan or record did not clearly indicate when the wound was debrided and on which days the wound vacuum was in use. Also, the care plan did not specify when approaches were added and when changes in dressing treatment began and ended. During an interview on 8/23/12 at 11:50 a.m., the director of nurses who reviewed the record stated the description of the 7/4/12 right heel wound did not appear to be a Stage 1 and was not sure if the peri wound was the measurement of the surrounding red area. The DON acknowledged weekly wound assessments were not always completed and the care plan was not consistently revised.	F 314		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	**F 441 Infection Control, Prevention Spread, Linens::** **Employees affected:** **One of the two employees identified is no longer employed at the center. The employee still employed at the center had a chest x-ray on 09/07/12 with negative results for TB.**	10/11/12

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F 441	Continued From page 17 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow the California Department of Public Health guidelines for the prevention and control of tuberculosis in California long-term health care facilities for two of five new	F 441	**The treatment nurse has been in-serviced by the DNS on appropriate hand hygiene and glove usage.** **2. Resident 2 experienced no negative outcome to the LN failure to follow hand hygiene in accordance with facility policy.** **How identify other resident having potential to be affected and corrective action taken:** **All residents and employees of the center have the potential to be affected.** **During the offer process for employment a candidate being offered a job and accepting will be interviewed to history of positive PPD. The hires with positive PPD will not be scheduled to work until they provide a chest x-ray report that validates negative for TB. The DSD will do in-service for nursing staff on hand hygiene and glove usage by 09/28/12.**	

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F 441	Continued From page 18 employees with a history of testing positive in the tuberculosis skin test (TST). A treatment nurse did not change gloves and perform hand hygiene during a wound dressing change. Findings: 1. The TST also known as the purified protein derivative (PPD) test is when a needle is inserted just below the first layer of a person's skin to introduce a purified protein derivative solution resembling the bacterium that causes tuberculosis. The person's body reacts in the form of an induration (bump) at the point of introduction which is measured in size three days later. Depending on the size, the resident is considered as either "negative" or "positive" for the tuberculosis bacterium. A one-step TST required doing the procedure only once. A two-step TST required repetition of the TST seven to twenty-one days after the date the first TST was placed. The state tuberculosis screening standard indicated that residents or new employees in a health care facility with no documented history of TST must have a two-step TST as part of the admission screening of residents or employees. In the case of a new employee with a history of testing positive on the TST, the state guideline indicated the asymptomatic employee should provide written documentation of a normal chest X-ray taken not more than 90 days prior to hire. (California Department of Health Services (now California Department of Public Health), California Tuberculosis Controllers Association, Joint Guidelines Prevention and Control of Tuberculosis in California Long-Term Health Care Facilities, October 2005, page 13):	F 441	**Systemic changes:** **ED will in-service all Department Managers, including the Business Office Manager (BOM) on appropriate health screen questions related to history of TB to review with new candidates. The new hires with history of positive PPD are not to be scheduled for duty until candidate has submitted a chest x-ray that is negative. The DSD/Infection Control Nurse is responsible to see that the above process is carried out and maintained and provide a report to ED monthly. DSD/Infection Control Nurse during routine infection control monitoring rounds monthly will visually validate employee compliance with hand hygiene and glove usage during care delivery.** **Licensed nurses were in-serviced on September 24, 2012 on hand hygiene.** **By Oct. 10, 2012 and in-service will be completed covering MRSA precautions.**	

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F 441	Continued From page 19 Employee health record review on 8/22/12 at 10:00 a.m. indicated the following new employees had a history of testing positive on the TST: a. Certified nurse assistant C (CNA C) was documented as having started work on 7/18/12 with a history of positive PPD. Although her chest X-ray dated 8/14/11 indicated she was clear of active tuberculosis, it was outside the 90-day prior to employment requirement range of 4/18/12 through 7/18/12. b. Licensed nurse D (LN D) hired on 5/23/12, was documented as having a history of positive PPD. The chest X-ray results in her file dated 8/29/11 indicated the chest X-ray was intended to treat her cough and bronchitis, but not to address LN D's history of positive PPD. The conclusion indicated no language such as clear of active tuberculosis and the chest X-ray was older than the 90-day prior to employment range of 2/23/12 through 5/23/12 During an interview on 8/22/12 at 11:15 a.m. the staff developer (SD) stated the two employee chest X-ray(s) did not meet the state requirement. 2. Record review on 8/20/12 indicated Resident 2 on 6/29/12 had a Methicillin Resistant Staphylococcus Aureus (MRSA, name of a bacteria) infection to his right lower leg wound. During an observation of a dressing change to Resident 2's right leg wound on 8/21/12 at 11:30 a.m., licensed nurse E (LN E) did not perform hand hygiene in accordance with facility policy. At 11:30 a.m. LN E gathered dressing supplies	F 441	**Monitor:** **The DNS will monitor for hand hygiene by randomly observing a minimum of 3 dressing changes a week for three months and report her findings to the monthly CQI Committee. If after 3 months 100% compliance is achieved, she may decide to discontinue the observations.** **The DSD/Infection Control Nurse will provide infection control reports for residents and employees to the CQI committee monthly with action plans as appropriate**	

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F 441	Continued From page 20 from the treatment cart to include several clean gauze and two 100 ml (milliliter, 28 ml is one ounce) normal saline bottles dated 8/20/12 (date when the bottles were first opened) and put them into an open plastic box. After removing the old dressing from Resident 2's right lower leg, without removing her gloves and performing hand hygiene LN E uncapped the normal saline bottle and poured saline solution into the clean gauze. LN E proceeded to apply the moist saline gauze over Resident 2's right leg wound without again removing her gloves and performing hand hygiene. The 10/2009 policy, "Hand Hygiene" indicated a situation that required hand hygiene included after contact with resident's body fluids. In an interview on 8/21/12 at 11:50 a.m. LN E confirmed saline bottles were reused. LN E acknowledged she should have performed hand hygiene after contact with the dirty dressing and before touching the saline bottle.	F 441		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the minimum 80 square feet per resident in five of 24 two resident rooms and 100 square feet in one of 15 single rooms. Findings:	F 458	**F 458 Bedroom Measure At Least 80 Sq. Ft/Resident:** **See attached.**	10/31/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KATHERINE HEALTHCARE	315 ALAMEDA AVENUE SALINAS, CA 93901

(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 458	Continued From page 21 On 8/21/12 at 9:30 a.m., an environmental tour of the facility was made with the maintenance director. Bedrooms 2, 3, 22, 23, and 24 intended for double resident occupancy, and Room 31, a single occupancy room, did not meet minimum square footage requirement. On 8/23/12, the square footage measurement of resident rooms were provided. Room 2 had a square footage of 154, Room 3 was 156.3, Rooms 22, 23, and 24 were 158.4 and Room 32 was 91.8. There were no quality of life or quality of care issues identified during interviews with residents, family members or staff related to the room size. Recommend continuance of room waiver.	F 458		
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	**F 514 Records – Complete/Accurate/Accessible** **Employee affected:** **Licensed Nurse N contacted the Physician on the day of the interview with the surveyor to obtain clarification for the medication Administration of the Lidoderm patch. The initial order read "Lidoderm patch 5% topically, apply for 12 hours than remove 12 hours. Place one patch to right and one patch to left base of neck for pain." This order was confirmed by the Physician who did not want to change the order at the time of clarification. The physician was called and he clarified that he wanted one patch on the right side and another one on the left side at the base of the neck and each left on for 12 hours. He then wanted the patches removed for 12 hours.**	10/11/12

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F 514	Continued From page 22 by: Based on observation, interview and record review, the facility failed to maintain a clinical record that was complete and accurately documented for one of 11 sampled residents (2). Resident 2's physician's order for a pain medication (Lidoderm patch) had an unclear administration instruction. Also, Resident 2 did not have wound assessments of his right leg completed on a weekly basis in accordance with facility policy. These failures increased the risk of confusion of care. Findings: 1. Resident 2's record was reviewed on 8/20/12. The resident had a physician's order dated 8/17/12 to apply Lidoderm patch 5% for 12 hours and to remove for 12 hours. Place one patch at right and one patch at left base of neck for pain. During a medication pass observation on 8/21/12 at 9:25 a.m., licensed nurse E (LN E) prepared to administer medications to Resident 2. After reading the Lidoderm order from the Medication Administration Record (MAR), LN 2 took out a pair of scissors. LN stated she did not know if she was to cut the Lidoderm patch in half and where to apply the right patch. She stated she could either place on the resident's right neck or the right leg near the amputation site. LN D then stated she will have the order clarified. In an interview on 8/22/12 at 3 p.m., director of nurses (DON) stated Resident 2's order to administer Lidoderm patch was not clear. 2. On 5/28/12, Resident 2's right leg wound on the Wound/Skin Evaluation and Documentation form was initiated. The documentation on the form were dated 5/28/12, 7/27/12, 8/2/12, 8/8/12	F 514	**Other Residents Who Have the Potential:** **All residents and staff of the center have the potential to be affected.** **Systemic Change:** **The facilities consulting pharmacist conducted an in-service for licensed staff on 09/12/12 on various types of patches, their uses, properties, handling, etc.** **Monitoring:** **The Director of Nursing Services will monitor for compliance by randomly auditing up to three medicated patch physician orders per month and report her findings to the monthly CQI committee for the next quarter and when 100% compliance is obtained for three months she will determine weither or not to continue the audit.**	

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
L & C DIVISION
SAN JOSE

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F 514	Continued From page 23 and 8/15/12. The August 2009 policy, "Skin Integrity Policy," directed nursing staff to complete a weekly skin inspection and to document on the Wound Evaluation and Documentation Form when a skin problem was identified and weekly thereafter until resolved On 8/23/12 at 11:50 a.m., DON stated weekly wound assessments were not always completed for residents.	F 514		