OK MB CCHO 5/03/12

PRINTED: 05/03/2012
FORM APPROVED

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000105	A. BUILDING _____ B. WING _____	C 04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITNEY OAKS CARE CENTER	3529 WALNUT AVENUE CARMICHAEL, CA 95608

(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) COMPLETE DATE
A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of complaint #CA00302688. Representing the Department of Public Health: HFEN 2104/25738 The inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility.	A 000	**PLAN OF CORRECTIONS** **"This plan of correction is prepared as part of the quality assurance process for the provider. This plan of correction and any attached documents are prepared with substantial reliance upon privileged peer review information and/or reports and as such are protected from discovery."** **"This plan of correction is prepared, submitted and/or executed solely because it is required by local, state and/or federal regulations, codes, and or guidelines. As this transmission is required by law, it is not a waiver of the provisions within applicable laws and regulations or any other**	
A 164	T22 DIV5 CH3 ART3-72311(a)(1)(B) Nursing Service--General (a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (B) Development of an individual, written patient care plan which indicates the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited. This Statute is not met as evidenced by: Based on observation, interviews and clinical record review the facility failed to develop an individual written care plan regarding the safeguarding of Patient A's dentures. This resulted in numerous incidents of lost dentures for Patient A over the last 3 years. Findings: An unannounced visit was made to the facility on 3/21/12 at approximately 10:55 a.m. The Director of Nursing (DON) was interviewed about the ongoing missing denture issue. The DON	A 164		

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A 164	Continued From page 1 acknowledged that the dentures had been lost several times over the years. The DON further stated that when questioned, the CNA's (Certified Nursing Assistants) always blame the next or last shift and that the charge nurses are supposed to monitor his denture placement once per shift. Patient A's room was observed. No denture cup was observed on the bedside table or on the stand by his bed. Patient A was observed on 3/21/12 at 11:00 a.m. in the activity room. He was seated in a wheelchair at a table and agreed to talk with the Department. Patient A was asked about his frequent missing dentures. He stated that, yes, they get lost but he doesn't know why. He was asked if he had any dentures in currently and he said no and opened his mouth for observation. There were no dentures evident in his upper jaw. His lower jaw showed his natural front teeth and no other teeth or dentures. At 12:25 p.m. a Licensed Nurse (LN) was interviewed and she stated that when his dentures are not in his mouth they should be put into a denture cup and into a drawer or on his table. At 12:30 p.m. Patient A was observed at lunch, being assisted by a CNA (CNA 1). His meal was chopped and he was able to eat it without apparent problems chewing or swallowing. CNA 1 was interviewed at that time about how well he could eat without his dentures. She said that he seems to do fine but that when he has his upper dentures in, he get uncomfortable and he will spit them out, then continue eating. She was asked if he waits until meal time to take them out or in his room? She said "Whenever or wherever he is	A 164	**codes, statutes or regulations.** **T22 DIV5 CH3 ART3-72311(a)(1)(B)** This residents' care plan has ben updated to reflect the use of dentures. Upon admission, the Interdisciplinary team (IDT) will develop individualized care plans that include measurable objectives and timetables to meet the resident's medical, nursing and psychological needs. The care plans will be updated quarterly, annually and as needed. Social services will keep an ongoing log of all the residents that have dentures.	5/5/12

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A 164	Continued From page 2 uncomfortable he will spit them out." At 1:05 p.m. CNA 2 was in Patient A's room and was interviewed regarding Patient A's dentures. CNA 2 stated that when eating Patient A tries to push his upper dentures out with his tongue. At this time an empty blue denture cup with opaque lid with Patient A's last name and room number was observed on his bedside table. A review of Patient A's clinical record showed no care plan regarding dentures in any manner, whether needed at meals nor monitoring their whereabouts. The Activities of Daily Living nor the Nutrition/Dietary care plans made any reference to the use of dentures. Review of the facility theft and loss logs showed 7 incidents of lost dentures for Patient A starting in 2009 up to 3/2012. The Social Services assistant was interviewed on 3/21/12 at 12:35 p.m. and she acknowledged the frequent and ongoing problems with his missing dentures and said she believed he removed the dentures himself. The facility has provided replacement dentures.	A 164	and will be responsible to update the information to the Activity of Daily living care plan. The Director of Nursing, will in-service the IDT on the care planning process and updating of care plans as the residents needs change. The Director of Nursing will monitor for compliance through the QA process.	