| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **055402** | A. BUILDING _____ B. WING _____ | **08/13/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **WINDSOR EL CAMINO CARE CENTER** | **2540 CARMICHAEL WAY CARMICHAEL, CA 95608** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0609<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, medical record and document review, the facility failed to 1) Report an allegation of staff mistreatment of [REDACTED]. These failures caused a delay in the Department's investigation of the alleged incident and had the potential to place other residents at risk for harm by the accused employee. Findings: The medical records demographics sheet reflected that Resident 1 was admitted to the facility on [DATE] with a medical history including stroke with resulting loss of movement and sensation to his dominant side, difficulty swallowing, and loss of the ability to communicate verbally. Other significant [DIAGNOSES REDACTED]. Several staff members stated or documented knowledge of an allegation of possible staff abuse involving Resident 1. In a 12:50 p.m., 3/18/20 interview, a night shift Charge Nurse (CN) indicated that 30 - 60 minutes after helping to clean and reposition Resident 1 on 2/25/20, the CN received a call from a family member who was concerned that staff had handled (the resident) roughly during care. The family member indicated she would be coming to the facility to speak with the Administrator. During a 1:41 p.m., 2/28/20 interview, Certified Nurse Assistant 1 (CNA 1) stated another of Resident 1's family members had approached her the morning of 2/25/20. The family member indicated Resident 1 had called him to report staff were abusing the resident and one caregiver threw (Resident 1) with force. CNA 1 introduced the family member to the Director of Staff Development (DSD) for further assistance. CNA 1 stated she did not file a report regarding the abuse allegation and was unaware if others did. In a 2:11 p.m., 2/28/20 interview, CNA 2 indicated she overheard Resident 1's family member discuss alleged night shift staff abuse of his relative with CNA 1 on 2/25/20. In a 1:19 p.m., 3/5/20 interview, the DSD recalled Resident 1's family member being upset during their conversation the morning of 2/25/20. The DSD stated the family member had been told by the resident that staff were being rough with the resident. During a 2:30 p.m., 3/5/20 interview, the Social Services Director (SSD) stated that on 2/25/20, the DSD reported to her a complaint about possible rough care involving Resident 1 which occurred earlier that day. A 2/25/20 internal report by the SSD indicated yet another of Resident 1's family members alleged that a CNA was rough while providing care. In the report, the SSD noted that the resident agree(d) with (the family member) by nodding yes - Patient & (relative) did not feel this was abuse. There was no documentation that an investigation into the allegation had been initiated and concluded prior to determining that no abuse or mistreatment had taken place. Staff education was provided after the incident, however. 2/26/20 Inservice Attendance Records stated educational goals included, Staff will understand allegations of abuse & best ways to prevent misunderstanding & miscommunication from occurring. In a 2 p.m., 2/27/20 nursing note, a Registered Nurse Supervisor (NS) wrote, At around 1400, resident's (family member) had come in to facility to present bruises (sic) that resident might have received from staff r/t (related to) pushing and rough to (resident) (sic) In a 2:42 p.m., 2/28/20 interview, the Director of Nursing (DON) stated that on 2/27/20, a family member alleged to her that someone (staff member) took their fists and beat (the resident) up. The DON indicated staff would need to report an allegation of resident abuse to the Department. At 4:56 p.m., 2/28/20, more than three days after the alleged abuse event, the Department received notification from CNA 1 of the allegation of physical abuse of Resident 1. In a 2:39 p.m., 8/11/20 interview, the Administrator stated that the SSD had discussed the mistreatment allegation with the resident and family member, they felt it wasn't abuse, and the matter was resolved that day. At that time, an investigation into the incident had not yet been initiated, however. Facility documents reflected that staff interviews regarding the allegation were not begun by the Administrator and Social Services Assistant (SSA) until 3/3/20. Results of the investigation were received by the Department on 3/4/20, six working days after the incident. Review of the facility's March 2018 Abuse Prohibition and Prevention Policy and Procedure reflected, Identification of Abuse .Complaints .or reporting of incidents .The Facility will report allegations of abuse .or mistreatment .even if no reasonable suspicion. When (:) .No later than 24 hours - all other conduct (actual, alleged, or potential .mistreatment .Reporting timeframes are based on real (clock) time, not business hours. To Whom (:) .Facility Administrator .State Survey Agency |
| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, medical record and document review, the facility failed to revise the comprehensive care plan to address repeated episodes in which Resident 1's feeding tube was found to have been removed. This failure may have precluded the facility from finding an effective solution to the repeated removals, preventing the hospital transfers required to reinsert the tube and enabling the resident to remain in the facility to receive all treatment ordered. Findings: The medical record demographics sheet reflected that Resident 1 had been admitted to the facility on [DATE] with a medical history including stroke with resulting difficulty swallowing and loss of the ability to communicate verbally. Physician orders [REDACTED]. Resident 1 was ordered to have medication for heart failure, high blood pressure, a brain blood vessel condition, anxiety and recurrent depression. Review of medical record SBAR (Situation/Background/Assessment/Recommendation) forms reflected that Resident 1's NG tube had been displaced from his stomach nine times during his stay, on 2/9/20, 2/12/20, 2/14/20, 2/17/20, 2/18/20, 2/20/20, 2/21/20, 2/25/20 and 2/26/20. Nursing progress notes documenting the last two times the NG tube came out provided examples of the impact the problem had on Resident 1's clinical care. 2/25/20 nursing notes indicated the NG tube was out, resulting in missed tube feeding and water at 3:59 p.m. and two missed blood pressure medication at 4 p.m. A 4:35 p.m. note read, Resident N[DEVICE] 'fell -out' (sic) this afternoon. Sent to hospital for replacement per standing order A 1:49 a.m., 2/26/20 note reflected, Pt (Patient, Resident 1) returned from ER (emergency room ) with 4 EMTs (Emergency Medical Technicians, paramedics; Resident 1 was severely obese and required extensive assistance to transport). NGT (NG tube) in place Seventeen hours later a 6:51 p.m., 2/26/20 nursing note read, I had received report that resident had a stomach ache, I Prepared (sic) his medications including Tylenol .for pain and went into resident's room about 1830 (6:30 p.m.) .to administer medications and feeding and found out that resident had pulled out his feeding tube one more time. I was shocked and exclaimed, 'OMG (Oh, my God) .you pulled out your tube again? I received report that you just got back at midnight from the hospital where you just had your tube re-inserted, I (sic) have all your feeding, blood pressure and pain medications here but I would not be able to administer all of that without your feeding tube in' .Resident demonstrated that he sneezed and that was the reason his tube came off (sic) .I called (ambulance) to come pick up resident .resident left facility back to (hospital) at 1930 (7:30 p.m.). Nursing notes indicated Resident 1 missed a tube feeding, water supplement, three blood pressure medications, a blood thinning medication and a cholesterol-lowering medication between 9:45 p.m. - 9:51 p.m., 2/26/20. The resident |

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

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.

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| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>returned to the facility at 1:40 a.m., 2/27/20, according to a 3:33 a.m., 2/27/20 nursing note. In an 11:16 a.m., 3/19/20 interview, a Nursing Supervisor (NS) familiar with Resident 1 stated she didn't think we could safely put down (reinsert) the tube in the facility. She added she was always asking how we could secure (the tube) and noted that a family member was always e-mailing Social Services about the (tube). When asked how often the facility cared for residents whose NG tubes became dislodged so frequently, the NS stated they don't often get such residents. When asked whether there should be a care plan addressing Resident 1's frequent NG removals, the NS stated, There should be a care plan. During an 11:37 a.m., 3/20/20 interview, the Minimum Data Set (an assessment tool) Coordinator, who initiated resident care plans on entry, stated that nursing unit Licensed Nurses were responsible for creating care plans for problems developing after admission. The MDSC indicated there should be a care plan addressing the recurrent NG discontinuation problem. In a 3:01 p.m., 3/9/20 interview, the Rehabilitation Program Manager (RPM) indicated that as a result of Resident 1 being in the hospital, physical therapy sessions on 2/12/20 and 2/18/20 were missed. In addition, the RPM stated the resident was sometimes fatigued during the day as a result of frequent trips to the hospital. In a 1:38 p.m., 3/6/20 interview, the Registered Dietitian indicated that one of the reasons he changed Resident 1's tube feeding formula to a higher-calorie product was to make sure he was being fed (was receiving sufficient calories) while he still had a tube in place. In a 3:35 p.m., 3/24/20 e-mail, the Administrator wrote, Strategies regarding NG tube - (Resident) was an alert resident, his own responsible party, and with a history of removing the tube during his acute stay. Other than educating him on the necessity of transfer to the acute there were no interventions (physical) as these would be considered restraints. Potential care planning interventions including the following were not documented as considered: - Interdisciplinary team problem-solving with the resident and his family to understand why he discontinued his tube, - Working jointly with the hospital to place a tube more comfortable for the resident, such as one with a smaller size or made of a different material, - Alternative taping techniques and/or products for increased tube security, - Collaboration with corporate consultants, other facilities, and/or hospital nursing resources for potential solutions, and - More frequent resident rounding. Review of the facility's 11/2012 Care Plan Goals and Objectives policy reflected, Care plans will incorporate goals and objectives which lead to the resident's highest obtainable level of function. |