STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055438	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALDERSON CONVALESCENT HOSPITAL	124 WALNUT STREET WOODLAND, CA 95695

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dignity was maintained for one of 27 sampled residents (Resident 1) when staff was standing over rather than sitting next to the resident while assisting the resident to eat. This failure increased the potential to diminish residents' self-esteem and self-worth. Findings: Resident 1 was admitted to the facility middle of 2014 with multiple [DIAGNOSES REDACTED]. During a concurrent dining observation and interview on 3/2/20, at 12:39 p.m., Certified Nursing Assistant (CNA) 1 was standing over Resident 1 while assisting Resident 1 to eat. When asked why the CNA was standing over the resident, CNA 1 stated, I like to stand. During an interview on 3/2/20, at 1:09 p.m., the Director of Staff Development (DSD) stated, I expect staff to sit, at eye level, not towering over the residents while assisting them to eat so as not to intimidate the residents. The DSD acknowledged CNA 1 should have sat at eye level while assisting Resident 1 to eat. During an interview on 3/5/20, at 7:45 a.m., the Administrator (ADM) stated, it was not appropriate for CNA 1 to be standing over the resident while assisting Resident 1 to eat. The ADM further stated, CNA 1 should have sat down. During a record review of a facility's policy and procedure (P&P) titled, Preamble to Resident's Bill of Rights, revised June 2009, the P&P indicated, .Patients have the rights .to be treated with consideration, respect and full recognition of dignity and individuality .The resident has a right to a dignified existence .
F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to have met its obligation to inform 3 non-sampled residents (Resident 53, Resident 71, and Resident 105) when the advance beneficiary notice (ABN) was not completed and issued in writing at the time of admission to the facility. These failures resulted in resident's and family's lack of information regarding the potential liability for payment of the services which are not covered under Medicaid or by the facilities per diem rate for Resident 53, Resident 71, and Resident 105. Findings: Resident 53 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Resident 53's Medicare Part A Skilled Services episode started 10/30/19. Resident 71 was re-admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Resident 71's Medicare Part A Skilled Services episode started 10/25/19. Resident 105 was re-admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Resident 105's Medicare Part A Skilled Services episode started 10/25/19. During a record review of a document titled, SNF (skilled nursing facility) Beneficiary Protection Notification Review, indicated no documented evidence of the ABN was completed in writing and provided to Resident 5, Resident 71, and Resident 105. During an interview on 3/5/20, at 9:47 a.m., the Administrative Assistant, the Human Resources/Payroll, and the Business Office (AA/HR/BO) stated they were not familiar with ABN and did not complete ABNs during resident admission. AA/HR/BO also stated the care conference served as the notice but done verbally. AA/HR/BO acknowledged the facility should have completed an ABN. During a record review of a facility's policy and procedure (P&P) titled, Resident Rights Under Federal Regulations, revised June 2009, the P&P indicated, Facility will inform each Resident .in writing, at the time of admission to the nursing Facility .and periodically during Resident's stay, of services available in Facility and of charges for those services, including any charges not covered under Medicare or by Facility's per diem rate.
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** Based on interview and facility policy review, the facility failed to make information regarding how to file a grievance or complaint available to the resident and family. The facility failed to ensure residents could file a grievance anonymously. This failure had the potential to result in the inability of residents and families to file a grievance and remain anonymous is desired. Findings: During the Resident Council meeting on 3/4/20 at 1:30 p.m. 9 out 9 residents stated they did not know how to file a grievance. During an interview with the Social Service Director (SSD) on 03/05/20 at 8:25 a.m., he was asked where residents can obtain grievance forms. The SSD stated the grievance forms were located at each nursing station and in the receptionist area. During a current observation, on 03/05/20 at 8:25 a.m., accompanied by the SSD, of nursing stations (NS) 1, 2, 3 and 4 the SSD proceeded to go behind all four NS desks and pull out a purple binder that contained the grievance forms. Residents were unable to access the grievance forms without asking staff where the forms were located and without having to go behind the NS desks. During a current observation, on 03/05/20 at 8:25 a.m., accompanied by the SSD, of the facility's reception area (access to area residents must open a door to get to reception area) grievance forms were located in a wall pocket container on the wall behind a door that must be opened to enter the reception area. Review of the facility's Grievance/Complaint Log revised 12/5/11 indicated, Social service staff shall assure that compliant/grievance forms are readily accessible to residents/families or surrogates at all times. The policy also indicated, If the resident/family or surrogate wishes to file a complaint or grievance, social service staff shall assist with completion of the complaint/grievance form.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility facility to ensure assessments accurately reflected the resident's status for 1 of 27 sampled residents (Resident 49). This failure had the potential to result in the resident to receive care that is not appropriate. Findings: Resident 49's clinical record was reviewed and contained a Quarterly MDS (Minimum Data Set-an assessment tool), dated 9/26/19 and an Annual MDS, dated [DATE]. Both MDSs indicated Resident 49's BIMS (Brief Interview for Mental Status- a brief screening that aids in detecting cognitive impairment) scores were 00. Under the section C0500. BIMS Summary Score the directions indicted Enter 99 if the resident was unable to complete the interview. Under the next section C0600. Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted? The staff member filling out this section was to either enter 0. No (res was able to complete Brief Interview for Mental Status) Skip to C1310, Signs and Symptoms of [MEDICAL CONDITION] or enter 1. Yes (resident was unable to complete Brief Interview for Mental Status) Continue to C0700, Short term memory OK. The staff member entered the code 0 indicating Resident 49 was able

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

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F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) to complete the Brief Interview for Mental Status, which was inaccurate. The staff member should have entered 1 indicating the resident was unable to complete the Brief Interview for Mental Status and the section Staff Assessment for Mental Status (sections C0700-C1000) should have been completed. During an interview with the Director of Nursing (DON) on 3/4/20 at 3:33 p.m. she confirmed Resident 49's MDS, dated [DATE] and 12/18/19 were not coded correctly. The DON indicated the the BIMS score (section C0500) should have been coded a 99 and sections C0700-C1000 should have been filled out.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation of medication pass administration, interview, and record review the facility failed to ensure one of three residents (Resident 113) received proper administration of a medication as ordered by the physician. This failure had the potential to result in a mouth infection. Findings: Resident 113 was admitted to the facility in 2017 with a [DIAGNOSES REDACTED]. During an observation on 3/4/20 at 8:30 a.m., of medication pass administration for Resident 113, with Licensed Nurse (LN 5), LN 5 delivered an inhaled dose of medication to Resident 113. Resident 113 took two puffs from the inhaler with the assistance from LN 5. LN 5 did not have the resident rinse her mouth after the doses were administered as per the doctors order. During an interview on 3/4/20 at 9:40 a.m., with LN 5, LN 5 stated, Oh, I missed that, I should have had her rinse her mouth. During an interview on 3/4/20 at 10:11 a.m., with the Director of Nurses (DON), DON stated that she expected the nurses to have the residents rinse their mouth after inhaler use and agreed that was the standard they should be held to. During a review of [MEDICATION NAME].com , dated March 2019, indicated, [MEDICATION NAME] HFA can cause serious side effects, including: fungal infections in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using [MEDICATION NAME] HFA to help reduce your chance of getting thrush.
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure personal hygiene was maintained for one of 27 sampled residents (Resident 101) when her fingernails were dirty and untrimmed. This failure had the potential to injure Resident 101's skin and promote spread of infections as well as negatively impact the resident's psychosocial well-being. Findings: Resident 101 was admitted to the facility mid to late of 2009 with multiple [DIAGNOSES REDACTED]. A review of the most recent Minimum Data Set (MDS, an assessment tool) dated 1/25/20 indicated Resident 101's cognition as severely impaired. The MDS reflected Resident 101 required extensive assistance on ADLs (activities of daily living) and 1-person physical assist for personal hygiene. During a concurrent observation and interview on 3/2/20, at 3:09 p.m., Resident 101's fingernails were noted to be untrimmed approximately 0.5-1 inch in length from the fingertips, jagged, dirty with black substance underneath the nail beds. When Resident 101 was asked about her nails, Resident 101 spoke to Certified Nursing Assistant (CNA) 2 in Spanish and confirmed Resident 101 wanted her nails trimmed. During an interview on 3/3/20, at 2:03 p.m., the Assistant Director of Nursing (ADON) acknowledged Resident 101's fingernails were long, untrimmed, and dirty. The ADON further acknowledged, Resident 101's fingernail condition was inappropriate. The ADON stated, (Resident 101's fingernails) should have been trimmed. Resident 101 was diabetic so Licensed Nurses (were) supposed to cut the fingernails. During a record review of a facility's policy and procedures (P&P) titled, Hygiene and Grooming, revised October 2010, the P&P indicated, To prevent spread of infections during grooming/personal hygiene .assist residents with hygiene and grooming .Residents who are dependent in grooming shall have their nails cleaned .and clipped .Residents with diabetes shall have nails clipped by a licensed nurse.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control procedures were followed for a census of 114 when: 1. Licensed Nurse did not wash hands between glove changes during wound care for Resident 111 and Resident 276; and, 2. Laundry staff held newly laundered clothes against her uniform; and, 3. Resident 81 had an expired humidifier bottle; and, 4. Resident 225 had expired nebulizer tubing; and, 5. Resident 30's catheter bag was found on the floor These deficient practices had the potential to spread infections. Findings: 1. Resident 276 was recently admitted to the facility with [DIAGNOSES REDACTED]. She was receiving daily wound care to her left foot. During an observation on [DATE] at 9 a.m., with Licensed vocational nurse (LN 3), LN 3 performed wound care on Resident 276's feet. During the wound care procedure LN 3 removed her gloves and donned new gloves without washing or sanitizing her hands after she removed the dirty dressing and again after cleaning the wound. Resident 111 was admitted in October of 2019 with a [DIAGNOSES REDACTED]. She was receiving daily wound care to her left lower leg. During an observation on [DATE] at 9:00 a.m., with LN 3, the LN 3 performed wound care on Resident 111's left lower leg. Twice during the wound care procedure LN 3 removed her gloves and donned new gloves without washing or sanitizing her hands between the glove changes. Once was after she cleaned the wound, and again after she applied gauze to the wound. During an interview on [DATE] at 9:30 a.m., with LN 3, LN 3 stated that she did not wash her hands after every glove change. During an interview on [DATE] at 9:32 a.m., with the Director of Nurses (DON), the DON confirmed that the expectation was to wash or sanitize hands after removing gloves. During a review of the facility's policy and procedure (P&P) titled, Hand Hygiene, dated [DATE], the P & P indicated, PURPOSE. To prevent spread of infections .HAND HYGIENE is the single most important method of infection control .PROCEDURE: HAND HYGIENE IS MANDATORY IN THE FOLLOWING SITUATIONS .After removing gloves . 2. During an observation on [DATE] at 1:40 p.m., in laundry room, LS 1 removed the resident's newly laundered clothes from the dryer and placed it to the blue cart. She held it close to her uniform as she carried it to the clean area. During an interview on [DATE] at 1:49 p.m., in laundry room, The LS stated, They're not supposed to touch the clothes with their uniform. During an interview on [DATE] at 1:51 p.m., in laundry room, LS 1 stated, Yes, it touched my uniform. During a review of the facility's policy and procedures titled LAUNDRY AND LINEN INFECTION CONTROL, revised ,[DATE], indicated .1. Clean linen shall be stored, handled and transported in a manner to prevent cross contamination. 3. Resident 81 was admitted to the facility in 2019 with a [DIAGNOSES REDACTED]. A review of the Physician orders [REDACTED]. During a concurrent observation and interview with Licensed Nurse 1 (LN1) on [DATE] at 9 a.m., LN1 verified the O2 humidifier bottle was dated [DATE]. LN1 stated, It should be changed every 5 days. 4. Resident 225 was admitted to the facility in 2020 with a [DIAGNOSES REDACTED]. A review of the Physician orders [REDACTED]. During a concurrent observation and interview with the Assistant Director of Nursing (ADON) on [DATE] at 9:15 a.m., the ADON verified the nebulizer (a device used to administer medication in the form of a mist using O2) oxygen tubing was dated [DATE]. The ADON stated, O2 tubing is to be changed every 10 days. A review of the facility's policy titled, Oxygen/Nebulizer Tubing Policy revised [DATE] indicated, Oxygen and nebulizer tubing will be changed every 10 days and PRN (as needed) damaged/broken nebulizer sets will be cleaned between each use. Humidifier will be changed every 5 days and shall be dated when applied . During an interview with the Director of Nursing (DON) on [DATE] at 10 a.m., the DON stated,Its the facility's policy to change the O2 tubing every 10 days and the humidifier every 5 days. 5. Resident 30 was admitted to the facility in 2014 with a [DIAGNOSES REDACTED]. A review of the Physician orders [REDACTED]. A review of the facility's policy titled, Catheter Care, Urinary revised [DATE] indicated, Do not allow the catheter tubing, bag, or spigot to touch the floor .