STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056216	A. BUILDING _____ B. WING _____	**04/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANTECA CARE AND REHABILITATION CENTER	**410 EASTWOOD AVE MANTECA, CA 95336**

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 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident rights were respected for one of nine sampled residents (Resident 1), when Resident 1 refused to agree to an antidepressant medication (a medication used to treat depression), the medication was ordered by the facility anyway, and an attempt was made to administer the medication. This failure placed Resident 1 at potential risk of receiving an unwanted medication and potentially cause her to feel her wishes were not important. Findings: Resident 1 was admitted to the facility in 2019 with [DIAGNOSES REDACTED]. Review of Resident 1's clinical record indicated a physician assistant specializing in behavioral health (PABH), visited Resident 1 for an evaluation on 5/14/19. Review of Resident 1's INFORMED CONSENT OF PSYCHOTHERAPEUTIC MEDICATIONS (the consent form is completed to indicate the ordering clinician has given a resident information about the risks and benefits of the medication proposed) dated 5/14/19, indicated Resident 1 refused to give consent for [MEDICATION NAME] (medication used to treat depression). Review of physician orders for Resident 1, dated 5/14/19, indicated, (brand name for [MEDICATION NAME]) 20 mg (milligram-a unit of measure) one QD (every day). Review of Resident 1's clinical record, Medication Administration Record [REDACTED].Give 1 capsule by mouth one time a day .Order Date-5/14/2019 1330 (1:30 p.m.) was scheduled to be given on 5/16/19 at 7:30 a.m. Review of Resident 1's MAR for the dose of [MEDICATION NAME] scheduled for 5/16/19 indicated Resident 1 refused the medication. A COMMUNICATION-with Physician document dated 5/16/19, indicated, .CALL PLACED TO (PABH) REGARDING (brand name [MEDICATION NAME]) .RESIDENT REFUSED TO GIVE CONSENT AND THEREFORE WHEN IT WAS OFFERED TO HER THIS MORNING .RESIDENT REFUSED MEDICATION . Review of physician orders for Resident 1 dated 5/16/19, at 10:22 a.m., indicated, .(PABH) gave telephone order to DC (discontinue) (brand name [MEDICATION NAME]) due to patient refused to give consent . During an interview on 6/21/19, at 12:17 p.m., with the director of nursing (DON), the DON indicated the PABH ordered the antidepressant for Resident 1 and the medication was added to the MAR indicated [REDACTED].it (medication) shouldn't be administered until resident consents. It (the refusal of the antidepressant) was not endorsed (communicated) properly. The nurse coming in didn't know .Chart needs to have a flag somehow if no consent .so medication is not given .not flagged on this occasion . Review of the facility policy titled, Informed Consent undated, indicated, .The facility shall ensure that patient rights are not to be violated .Physician's orders related to the use of psychotherapeutic drug .shall not be initiated until an informed consent is obtained .The facility shall verify with the physician or other health professional, that the patient .gave informed consent prior to the initiation of psychotherapeutic drugs . Review of the facility policy titled, REFUSAL OF TREATMENT undated, indicated, .Our facility honors the resident's right to refuse treatment .

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.