Acceptable 3/13/13 LL

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056098	A. BUILDING _____ B. WING _____	12/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTHCARE CENTER	625 Cottonwood St, Woodland, CA 95695-3614 YOLO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit: CLASS B CITATION -- PATIENT RIGHTS 03-1662-0009770-S Complaint(s): CA00248164 Representing the Department of Public Health: Surveyor ID # 17069, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Nursing Service - Patient Care - 72315 (b) Each patient shall be treated as individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind. An unannounced visit was made to the facility on 12/14/10 to investigate an entity self-report #CA00248164. The Department determined the facility failed to: 1) Ensure Patient A was free from physical abuse. This failure resulted in Certified Nursing Assistant (CNA) 1 putting both her hands over Patient A's mouth and telling the patient to stop screaming. Patient A's clinical record was reviewed on 12/14/10 and documented he was a 65 year old male with a re-admission back to the facility on 3/16/10. Patient A's diagnoses include altered		To begun immediately & be corrected by 3/13/13 Conducting a client in letter given on 3/7/13	

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[signature]	ADMINISTRATOR	3/7/13

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	Continued From page 1 mental status, Schizophrenia, spastic quadraparesis (muscle weakness affecting all four limbs), and dementia with behavioral disturbances. Patient A's Quarterly Minimum Data Set (MDS, a standardized assessment tool), dated 9/24/10, documented Patient A as having both short or long-term memory problems, as having severely impaired cognitive skills for daily decision making, usually able to make himself understood and usually able to understand others. The MDS documented Patient A as needing extensive assistance with bed mobility, transfers, walking in room and corridor, locomotion on and off the unit, dressing, eating, toilet use and personal hygiene. The MDS also documented Patient A as having verbally abusive behavioral symptoms, socially inappropriate/disruptive behavioral symptoms and resists care. Patient A's clinical record contained a care plan regarding "Impaired Mood: Mood and Behavior," dated 5/11/10, which indicated Patient A had a behavior of "continuous yelling" and "continuous fixation and screaming about [his] bowels....." Review of a Nurse's Note, dated 11/2/10 at 12:43 p.m. indicated two staff members (Maintenance & Janitor) reported they were working inside Room 124's bathroom when Patient A starting yelling/screaming and then the tone of the Patient A's voice changed. The two staff member went out of the bathroom to check on the patient and observed CNA 1 covering Patient A's mouth with both her hands. CNA 1, upon seeing the other two staff members, took her hands off and left the room.		The following constitutes the facilities response to the findings of the Department of Public Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statement of deficiencies. This plan of correction is prepared as required by the provisions of the Health and Safety Code, 42 CFR and constitutes the facilities written credible allegation of compliance. CLASS B CITATION—PATIENT RIGHTS 03-1662.0009770-S Nursing Service-Patient Care-72315 a. The patient discharged from the facility on 11/9/2010. b. Facility staff consistently monitors for potential abuse and follow all federal and state regulations required for preventing and reporting resident abuse. No other residents were affected. All potential issues are reported on the SOC 341 and forwarded to the Department within 24 hours of report.	3/11/13

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	Continued From page 2 The Nurse's Note documented Patient A was assessed with no injuries noted and no complaint of pain or discomfort from Patient A. According to the Nurses Note Patient A was asked about the incident. Patient A stated, "I think it happened yesterday or may be not." CNA 1 was sent home immediately. The facility's investigation report was reviewed on 12/14/10 and contained a written statement by CNA 1. According to CNA 1's statement, dated 11/2/10, she went into Room 124 because Patient A was yelling and screaming. CNA 1 stated she saw that Patient A had his pull-up briefs down around his knees. CNA 1 stated she tried to communicate with him that she was going to try to help him pull the briefs up. CNA 1 stated Patient A kept yelling so she put her mouth next to his ear to tell him to stop screaming. CNA 1 stated she was standing right next to Patient A when she was talking to him when he started to yell again so she "put my hand on his mouth till I could move my head away from his mouth." CNA 1 then stated she asked Patient A to roll over so she could pull his brief up. When Patient A rolled over he yelled "Ow" but CNA 1 didn't know why. CNA 1 stated Patient A started yelling again when I saw his nose was running so I wiped his nose. She then stated she asked Patient A to help her pull up his brief again but Patient A continued to yell again. CNA 1 then stated she asked Patient A to open his eyes to look at her. The facility's investigation report also contained a written statement by Maintenance. Review of		*Continued from previous page* c. Staff receives abuse identification and prevention training at least annually. The hiring practice has been revised to include a comprehensive criminal background check and drug test in addition to a check of the OIG exclusion list, Megan's Law, license/certification verification, and thorough reference checks to screen for potential issues with candidates for hire. d. New hire employee files are routinely audited to ensure all screen information is present, reviewed, and employee is eligible for employment. The facility Administrator is responsible to ensure all new employees are adequately screened prior to hire, including a face-to-face interview. Mandatory abuse training records are reviewed periodically to ensure all current employees receive adequate education to ensure all patients are free from abuse. Anomalies will be forwarded to the QA committee for review and recommendation.	

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	Continued From page 3 Maintenance's statement, dated 11/2/10, indicated he was in Room 124's bathroom repairing a toilet when he heard Patient A screaming and then he heard what sounded like when someone is holding their breath. The Maintenance Staff told the janitor to look out the bathroom door. The Janitor told him he saw CNA 1 holding both her hands on the patient A's mouth. Maintenance Staff state he then looked and also saw CNA 1 had both her hands on Patient A's mouth and telling him to stop screaming. Maintenance was interviewed on 12/14/10 at 9 a.m. He confirmed what was written in his statement. He and the Janitor were in Room 124 replacing a toilet when he heard screaming twice then he didn't hear anything. He stated he asked the Janitor to look outside the door to see if the patient was alright. The Janitor told him he saw CNA 1 holding both her hands over Patient A's mouth. The Maintenance Staff then went out of the bathroom door to check for himself and stated he saw CNA 1 with both her hands over Patient A's mouth. During an interview with the Janitor, on 12/14/10 at 9:08 a.m., he stated Maintenance and him were in Room 124 changing the toilet out when they heard screaming then what sounded like muffled sounds. The Janitor stated Maintenance asked him to peek out the door to see if the patient was alright. When he looked out the door he saw CNA 1 with both her hands over patient A's hands. He stated he told Maintenance what he observed and Maintenance then looked out the door and also observed CNA 1 with both her hands over Patient A's mouth. The			

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	Continued From page 4 Janitor further stated when Maintenance looked out the door CNA 1 saw him and she immediately left the room. The Administrator was interviewed, on 12/14/10 at 9:48 a.m. He stated based on the CNA 1's statement he substantiated the allegation of abuse and terminated CNA 1. The Department determined the facility failed to: 1) Ensure Patient A was free from physical abuse. This failure resulted in Certified Nursing Assistant (CNA) 1 putting both her hands over Patient A's mouth and telling the patient to stop screaming. These violations had a direct or immediate relationship to the health, safety or security of a long-term care facility patient or resident.			

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