CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

Post-Certification Revisit Report

State Form: Revisit Report

12/4/2012

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
555844	A. Building _____ B. Wing _____	1/7/2013 CITATION #: 110007964

Name of Facility	Street Address, City, State, Zip Code
Novato Healthcare Center	1565 Hill Rd, Novato, CA 94947-4063

1/7/2013 FSA

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y6) Date	(Y4) Item	(Y5) Date
ID Prefix F323	Correction				
Reg. #	Completed				
LSC	1/7/13				

COPY

Reviewed By State Agency ✓	Reviewed By	Date: 1/8/13	Signature of Surveyor: Eileen Bathen	Date: 1-8-13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 02/16/2011 V# I5HC11

_____ Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 11-2259-0007964-F

Date: 12/07/2012 Time: 1250

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Type of Visit : Complaint Investig.
Incident/Complaint No.(s) : CA00257346

Licensee Name: Novato Healthcare Center, LLC

Address: 5120 W. Goldleaf Circle, Suite 400 Los Angeles, CA 90056

License Number: 010000355 Type of Ownership: Limited Liability Company

Facility Name: Novato Healthcare Center
Address: 1565 Hill Rd Novato, CA 94947
Telephone: (415) 897-6161
Facility Type: Skilled Nursing Facility Capacity: 181
Facility ID: 010000940

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $1,000.00	DEADLINE FOR COMPLIANCE 1/7/13 12:00 a.m.
F323	**CLASS B CITATION -- PATIENT CARE**		

F323 §483.25(h) Accidents & Supervision

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

The facility failed to ensure adequate supervision and assistance devices to prevent injury to Resident 1 on two occasions when: 1) Staff did not provide adequate supervision to Resident 1 to prevent Resident 1 from falling on 11/5/10. Resident 1 sustained a fractured clavicle (collar bone) and required hospitalization for three days and 2) Staff did not ensure adequate supervision of Resident 2 when staff failed to evaluate and manage Resident 2 's wandering behaviors and staff failed to provide sufficient assistance to prevent a fall during ambulation of Resident 1 on 1/22/11. Resident 2 knocked down Resident 1 when Resident 2 wandered into Resident 1's room unsupervised. Resident 1 sustained a closed head injury with a complicated facial laceration that required extensive sutures.

Findings:

Incident of 11/5/10:

Name of Evaluator: for Jan Hale
Jan Hale
HFEN

Evaluator Signature : HFE II

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature :

Name : Dayron Treude

Title : Administrator

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	CNA E found Resident 1 on the floor on her right side by the door of her room on 11/5/2010. Resident 1 was agitated, combative, grimacing, and moaning. She was admitted to an acute care facility with a black and blue mark on her right forehead, a hematoma on the right side of her forehead, and a new right clavicle fracture. 1. During an interview on 2/11/11 at 3:15 p.m., Certified Nursing Assistant (CNA) E stated Resident 1 tried to stand but was unstable and could not balance herself without help. CNA E stated she discovered Resident 1 on the floor near the door of her room with the right side of her head touching the floor sometime before dinner on 11/5/10. Resident 1's clinical record was reviewed on 2/11/11 at 11 a.m. and 2/14/11 at 4:30 p.m. A minimum data set (MDS) assessment tool, dated 10/20/10, showed Resident 1 needed an interpreter. Her hearing was adequate and her speech was clear. She was sometimes able to understand others and sometimes able to make herself understood. Resident 1 suffered both long and short term memory problems and wandered daily. The MDS indicated she required supervision and setup assistance from staff to transfer between surfaces, walk in room and corridor, and to move between locations. The MDS indicated her balance during transitions and walking was "not steady." She was "only able to stabilize with human assistance". Resident 1 required assistance to steady herself when moving from seated to standing and transferring between bed and chair. Resident 1 did not use any mobility devices (i.e. walker, WC, cane). The MDS of 10/20/10 indicated Resident 1 had had one fall with injury since the previous assessment and Resident 1 did not receive physical or occupational therapy or restorative nursing services including transfer or walking. A "Fall Injury Prevention" care plan dated 5/11/09 indicated Resident 1 had a history of falls. The care plan identified interventions to assist with ambulation and transfers as needed. A Change in Condition Assessment, (CIC) dated11/5/10, indicated Resident 1 was at risk for falling due to poor safety judgment, side effects of medications, disorientation/confusion, unsteady gait, and the need for assistance to the restroom. The CIC indicated CNA E found Resident 1 on the floor on her right side by the door of her room agitated, combative, grimacing, and moaning. The CIC further indicated Resident 1 had a hematoma (localized swelling, filled with blood) that measured three centimeters (cm) x three cm. and a bleeding abrasion on her right forehead that

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	measured 0.2 cm x 0.2 cm. Physician's order of 11/5/10 read to send Resident 1 to an acute care facility emergency room for CT-scan (computer imaging exam) of her head after the fall. The acute care admission history & physical (H & P), dated 11/5/10, indicated Resident 1 was admitted due to a black and blue mark on her right forehead, a hematoma on the right side of her forehead, and a new right clavicle fracture. A "Nursing Admission Assessment", dated 11/8/10, indicated Resident 1 was re-admitted to the Skilled Nursing Facility (SNF) from the acute care hospital after a fall on 11/5/2010. The assessment indicated Resident 1 had a right clavicle fracture. There was a green/yellow bump on her right forehead that measured 4 cm x 3.6 cm, and green / yellow discoloration on her right face, right neck, right shoulder and her clavicle. The assessment showed a dry scab from a skin tear below the right knee and blue discoloration on the left foot. The assessment further indicated Resident 1's right arm was kept in a sling at, "All times." When interviewed on 2/15/11 at 11:05 a.m., Resident 1's physician stated Resident 1 had fallen a number of times prior to 1/22/11. He indicated the ecchymosis from the head injury usually took 8 weeks to clear and the center of the hematoma may never clear. He stated Resident 1 ambulated independently for short distances, had "pretty good" balance, but was also weak, had "mild" dementia. Resident 1's physician stated that after dinner and breakfast there were a lot of people walking around in the facility and, "That confusing mass migration may contribute to some of the falls." Resident 1's physician stated Resident 1 may have needed to reside in an area where there were not a lot of people "milling around" and the rooms to doors were not all open. The facility policy, "Fall Prevention and Incident Management," dated 9/8/09, indicated it was the facility policy to plan interventions and implement procedures to prevent falls and / or accidents. Incident of 1/22/11: On 1/22/11 at 2:40 a.m., Resident 2 entered Resident 1's room, tried to get in Resident 1's bed, and knocked down Resident 1 and CNA C. Resident 1 fell to the floor face first and suffered a closed head injury, with a complex facial laceration which required approximately 22 sutures.

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

On 2/14/11 at 10:10 a.m., Resident 2 lay in bed in the fetal position, making chewing motions. Resident 2 stared straight ahead and was non-responsive to questions. Resident 2 was unattended and there was no Velcro barrier on her door.

On 2/14/11 at 11:50 a.m., the Social Services Director (SSD) stated Resident 2 wandered into other residents' rooms and got in their beds every day during all shifts.

On 2/14/11 at 4:50 p.m., Licensed Nurse (LN) G stated Resident 2 wandered and needed to be redirected by staff at, "All times." LN G stated Resident 2 was forgetful and tended to get lost when trying to find her room. LN G stated Certified Nursing Assistants (CNA) were successful at preventing Resident 2 from getting into other residents' rooms, on a "few occasions."

Resident 2's clinical record was reviewed on 2/14/11 at 1 p.m.

The Minimum Data Set (MDS) assessment tool, dated 9/9/10, indicated Resident 2 had short and long term memory problems, severely impaired cognitive skills, rarely understood others, was restless, made repetitive physical movements, and wandered. The MDS indicated Resident 2 required supervision while moving in corridors.

The Resident Assessment Protocol (RAP), dated 9/24/10, generated from the 9/9/10 MDS indicated Resident 2's wandering behavior triggered a nursing care plan for mood/behavior.

The "Mood and Behavior," care plan, dated 6/10/10, indicated Resident 2 wandered and, "Throws herself in bed when she wants to go to bed."
The care plan lacked documented evidence of any specific approaches to address the wandering or the "throwing" of herself into bed. The care plan document had a typewritten choice of an approach to evaluate the need for wandering management and assist with ambulation as needed, however this approach was not checked as an active intervention.

The "Change in Condition," (CIC) note, dated 12/8/10, indicated Resident 2 was confused, wandered, and "jumped" into bed whenever she (Resident 2) tried to lie down.

"Resident Weekly Summary," (RWS) notes for 1/18/11 - 1/24/11, dated 1/24/11,

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	indicated Resident 2 was confused and forgetful, but there was no significant change in Resident 2's condition. The 1/24/11 note lacked documentation of the incident related to Resident 2 wandering into Resident 1's room and knocking her (Resident 1) down on 1/22/11. RWS notes, dated 6/28/10 - 2/9/11, lacked documentation related to monitoring Resident 2's episodes of wandering and/or throwing herself into bed. On 2/14/11 at 11:40 a.m., CNA C stated Resident 2 tried to get into other resident's beds every day. CNA C signed a declaration which documented "On...1/22/11 at 2:40 a.m., I took (Name deleted - Resident 1) to the restroom, on the way back to her bed, I was holding her by her upper arm when (Name deleted - Resident 2) ran toward (Name deleted - Resident 1's) bed.... (Name deleted - Resident 2) bumped me from behind and knocked us forward. (Name deleted - Resident 1) fell to the floor face first... (Name deleted - Resident 2) tries to get in other resident's beds everyday..." During an interview on 2/15/11 at 4:40 p.m., the Director of Nursing (DON) stated Resident 2 wandered, did not know where her room was, and required assistance from staff to redirect her (Resident 2). The DON stated she was not aware Resident 2 went into other residents' rooms. On 2/11/11 at 9:55 a.m., Resident 1 had a black scab in the middle of her forehead and there was bruising on her left cheek. Resident 1 moaned and pointed her finger in response to greeting, but did not form words. During a closer observation on 2/14/11 at 10:20 a.m., Resident 1 had green and purple discoloration around both of her eyes, green discoloration in her hair line, and a black scab on her forehead. An acute care emergency department (ED) report, dated 1/22/11, indicated Resident 1 suffered a closed head injury, and a complex facial laceration (about 10 centimeters) which required approximately 22 sutures in Resident 1's scalp. The ED report indicated closing the laceration was difficult due to the complexity of the laceration and the large amount of trauma. A computerized tomography (CT) scan (CT scan - uses x-rays to make detailed pictures of the inside of the body) of Resident 1's head, dated 1/22/11, indicated Resident 1 suffered soft tissue swelling on her frontal scalp. A, "Change in Condition Assessment," (CIC) dated 1/22/11 at 2:40 a.m., indicated

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	Resident 1 fell to the floor when a CNA that was assisting Resident 1 lost her grip on Resident 1's right arm due to another resident rushing past. The CIC indicated Resident 1 sustained a laceration to her forehead. An interdisciplinary conference note, dated 1/24/11, indicated the 1/22/11 fall was, "Best attributed to...CNA pushed by another resident who walked into the room accidentally." When interviewed on 2/11/2011 at 10:30 a.m. Licensed Nurse B stated there was no padded mat next to Resident 1's bed on 1/22/11. Therefore, the facility violated the regulation when: 1. Facility staff did not provide supervision to prevent Resident 1 from falling and suffering a fractured clavicle (collar bone) on 11/5/10, resulting in a three day admission to an acute care hospital and, 2. Facility staff did not evaluate, manage or assist Resident 2 for unsafe wandering behaviors. This resulted in Resident 2 wandering into Resident 1's room and knocking Resident 1 down to the floor on 1/22/11. Resident 1 sustained a closed head injury and a complicated facial laceration that required approximately 22 sutures. These failures had a direct or immediate relationship to the health safety and security of Resident 1 and Resident 2.

State of California - Health and Human Services Agency

Department of Public Health

CIVIL MONEY PENALTY ASSESSMENT

Facility : Novato Healthcare Center

DATE	CITATION #	CLASS	PENALTY ASSESSED	TOTAL DUE
12/07/2012	11-2259-0007964-F	B	$1,000.00	$1,000.00
SECTION(S) VIOLATED				
F323				

This citation has been issued as a Class B.

Full Payment Due By : 01/06/2013

PAYMENT OPTIONS

Per Health and Safety Code, Section 1428.1, licensee may pay 65% of the amount shown above in the "Total Due" within 15 business days after issuance of this citation, or the minimum amount defined by law, whichever is greater in lieu of contesting the citation (Class B Citation penalty minimum amount defined by law is $100). If licensee chooses not to exercise the 65% / 15 business day option, the full amount is due.

Make Check Payable To:

Department of Public Health
Include Citation Number

Mailing Address:

Licensing and Certification Program
Grant & Fiscal Assessment Unit
P.O. Box 189190
Sacramento, CA 95818-9190
(916) 322-2118

COLLECTION OF DELINQUENT PAYMENTS

CDPH will pursue collection of delinquent payments, including, but not limited to Medi-Cal offset (per Health & Safety Code, Section 1428). This will result in withholding of the licensee's Medi-Cal payments until the full amount of the citation is collected. In order to present a valid objection to the use of Medi-Cal offset, please contact the Grant and Fiscal Assessment Unit at the address listed above.

CONTESTING A CLASS B CITATION

A licensee may contest a class "B" citation or penalty assessment before an Administrative Law Judge or have the matter submitted to binding arbitration. (Health and Safety Code Section 1428.)

To contest a class "B" citation or penalty assessment, a licensee must send written notification to the Department advising of its intent either to adjudicate the validity of the citation before an Administrative Law Judge or to submit the matter to binding arbitration. (Health and Safety Code Section 1428.)

Please note, effective January 1, 2012, Assembly Bill No. 641 (Chapter 729, Statutes of 2011) amended Health and Safety Code Section 1428 to repeal the citation review conference process for "B" citations issued on or after January 1, 2012. Therefore, if a licensee exercised its right to a citation review conference prior to January 1, 2012, the citation review conference and all notices, reviews, and appeals thereof shall be conducted pursuant to Section 1428 as it read on December 31, 2011.

The citation review conference process is no longer available to a licensee for citations issued on or after January 1, 2012.

Any written notification must be sent to the district office that issued the citation and must be postmarked within fifteen (15) business days after the service of the citation. Please submit written notification to:

Department of Public Health
Licensing & Certification Program
Santa Rosa/Redwood Coast District Office
2170 Northpoint Parkway
Santa Rosa, CA 95407

Signature of District Manager/Designee

12/7/12
Date