Approved 8/2/16 Jshaur

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
	056380	A. BUILDING _____ B. WING _____	08/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VILLA LOS FELIZ NURSING CENTER	3002 Rowena Ave, Los Angeles, CA 90039-2005 LOS ANGELES COUNTY

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	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit: CLASS AA CITATION -- PATIENT CARE 92-2051-0011797-F Complaint(s): CA00415541 Representing the Department of Public Health: Surveyor ID # 25219, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. 42 CFR§ 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care. 42 CFR§ 483.20 (k)(1) Comprehensive Care Plans The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 483.25. 42 CFR§ 483.25 (h) ACCIDENTS		Country Villa Los Feliz Healthcare submits this response and Plan of Correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employee, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party.	

Event ID: WU6I11 8/2/2016 2:25:01PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADON — (X6) DATE: 08/02/2016

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 9

Every deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings 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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	The facility must ensure that – (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. On October 3, 2014, the Department received a complaint (CA00415541) that alleged Resident 1 had a fall on October 2, 2014, between 6:30 p.m. and 7 p.m., while she was getting her snack from the nourishment cart. The resident fell and sustained an injury to her head, and was transferred to the general acute care hospital (GACH), where she died the same day. The facility failed to ensure Resident 1's environment was free of accident hazards during the distribution of snacks, and failed to provide adequate supervision and assistance to Resident 1 in receiving her snacks from the nourishment cart. The facility also failed to monitor Resident 1's orthostatic hypotension blood pressure on the date she had the fall. Resident 1, who had a history of falls and was assessed as being a high risk for falls, was using her front-wheeled walker [(FWW) an assistive device to use for additional support to maintain balance or stability while walking] when she came to the nourishment cart to get her own snacks. When she let go of her FWW to grab snacks and put them in a plastic bag hanging from her FWW, she lost her balance and fell backwards hitting her head on the floor. As a result, Resident 1 sustained a fatal blunt head injury from the fall. She was sent to the GACH where she died on October		Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceedings on that basis. **Corrective action for residents found to have been affected by this deficiency:** Resident 1 was no longer a resident at the facility. **Corrective action for residents that may be affected by this deficiency:** IDT identified 12 other residents that might be potential for the deficient practice to occur. IDT met with individual residents on 3/23/15 and re-educated in regards to nourishment distributions. Quality Improvement Plan was initiated	

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	2, 2014, the same date of her fall. On March 19, 2015, at 11:32 p.m., during a telephone interview, Family Member 1 (FM 1) stated Resident 1 fell and hit her head. According to FM 1, Resident 1 had a previous fall without injury and she was under close supervision to prevent an injury from a fall. FM 1 stated this time she fell while she was getting snacks from the nourishment cart. On March 19, 2015, at 1:40 p.m., during the onsite investigation, a review of Resident 1's admission record indicated she was admitted to the facility on November 3, 2008, with diagnoses that included rib fracture, syncope and collapse [also known as fainting, passing out and swooning, a short loss of consciousness and muscle strength, characterized by a fast onset] and osteoporosis (a progressive bone disease that weakens bones and makes them susceptible to bone fractures). A review of the current Minimum Data Set [MDS-a comprehensive assessment and care screening tool] dated February 12, 2014, indicated Resident 1 had moderately impaired cognitive skills for daily decision-making, had poor vision (able to read large print only), required supervision (oversight, encouragement or cueing) and set up help only while walking with a FWW. Resident 1 required limited assistance in dressing, toilet use and personal hygiene, and required physical help in part of bathing activity. The MDS indicated Resident 1 was not steady when walking or turning around, even with her assistive device (FWW), and had a		on 10/14/14 in regards to fall prevention and management. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not reoccur:** DON/DSD will re-educate nursing staff in regards to residents' nourishment distribution procedures and safety by 10/10/15. This in-service education was initially initiated on 10/13/14 and 10/14/15. DON/DSD will re-educate licensed nurses in regards to	

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	history of falls. The Care Area Assessment (CAA) was triggered for falls as a problem area of concern requiring further assessment and a plan of care. A review of the Fall Risk Assessments dated August 12, 2014, indicated Resident 1 was a high risk for falls. Resident 1 was also assessed as having poor safety awareness and judgment, unsteady gait, and received multiple medications, including Vasotec, Clonidine (medications to treat high blood pressure), and Ultram (pain medication that may cause drowsiness, and dizziness, with increased risk for falls). A review of the physician's orders indicated the following: 1. Clonidine 0.2 milligram (mg) one tablet by mouth two times a day for high blood pressure, dated November 27, 2011. The adverse side effects included drowsiness, dizziness, dry mouth, nausea and vomiting. 2. Vasotec 10 mg at 9 a.m. every day, dated on November 11, 2011. The adverse side effects of these blood pressure medications included orthostatic hypotension (a condition in which your blood pressure falls when you stand up quickly, leaving you feeling dizzy or lightheaded). 3. Ultram 50 mg one cap by mouth one time a day for pain, dated November 21, 2013. The adverse side effects of Ultram included drowsiness and dizziness.		monitor adverse side effects of antihypertensive medications and completing of orthostatic hypotension blood pressure that could be a risk factor for safety in regards to fall. Activity Director will meet with resident council and review the nourishment distribution procedures to prevent any safety issues by 10/10/2015. This will be reviewed every month for 3 months.	

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	4. Monitor orthostatic hypotension (blood pressure while lying, sitting and standing). A review of the medication administration record (MAR) indicated Resident 1 had received the above medications as ordered. There was no documented evidence that indicated the adverse effects of the above three medications were monitored on the date Resident 1 fell and sustained a head injury. The resident's orthostatic hypotension blood pressure was not monitored on the date she had the fall. There was a care plan developed with a goal date of November 30, 2014, for the potential for recurrent falls/injury related to the presence of fall risk factors: history of falls, visually impaired, poor safety awareness, problems of impaired decision making, impaired judgment, predisposing disease or injury, heart medications, advanced age, osteoporosis and unsteady balance. The interventions to prevent falls and injury included to escort Resident 1 to activity programs for safety; keep the resident in frequently monitored areas; remind Resident 1 to use her ambulation device (FWW), and to keep her environment safe from hazards/clutter. On March 19, 2015, at 3:35 p.m., an interview was conducted with Certified Nursing Assistant 1 (CNA 1), who was assigned on the 3 p.m. to 11 p.m. shift, to pass nourishments on the day of Resident 1's fall incident. CNA 1 stated at approximately 6:45 p.m., while she was passing nourishments, Resident 1 was ambulating in the hallway with her		**Measures that will be put into place to ensure that this deficiency does not reoccur:** Social Service will validate with residents during random resident satisfaction survey. Charge nurses in each station will monitor the proper distribution of nourishments to ensure that they are distributed according to the plan. Findings will be reported to DON. The above POC will be reviewed in the QAA committee for further review and recommendations quarterly and as needed. Administrator and/or DON will report trends.	

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	FWW. Resident 1 started to pick multiple nourishments directly from the cart, and put them inside a plastic bag that was hanging on her walker, as she always did. While doing so, Resident 1 had to take her hands off of her FWW to place the items into her bag. Resident 1 then lost her balance and fell backwards, hitting the back of her head on the floor. CNA 1 stated she attempted to grab Resident 1 before she landed on the floor but she did not succeed. CNA 1 stated she summoned for help, and staff members rushed to the location. Vital signs were done, but Resident 1 was unresponsive, and the paramedics were called via 911. On March 19, 2015, at 4: 05 p.m., during an interview CNA 2 stated the charge nurse would announce when the nourishments were to be passed to the residents. CNA 2 stated ambulatory residents came all at once to the nourishment cart. Resident 1 walked with her FWW to the nourishment cart, took multiple items to place inside a plastic bag hanging on her walker. In doing so, when she took her hands off the walker, she lost her balance and fell backwards, hitting the back of her head on the floor. On March 19, 2015, at 4:45 p.m., during an interview Licensed Vocational Nurse 1 (LVN 1) stated that in the past, he observed Resident 1 take snacks directly from the cart because she did not have the patience to wait until the staff members served her snack. LVN 1 stated that in the past, he attempted to stop Resident 1 from taking snacks from the cart, but Resident 1			

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became upset and angry.

On March 19, 2015, at 5:15 p.m., during an interview, the director of Nurses (DON) stated CNA 1 had witnessed Resident 1's fall at the nourishment cart. The DON stated Resident 1 always picked up food from the cart by herself, so this behavior was not an isolated incident. If the staff handed her the food, Resident 1 became angry and upset. There was no documented evidence provided to indicate the facility had addressed this potential safety problem in Resident 1's plan of care.

A review of the facility's policies entitled "Snack Cart - H.S." and "Nourishment", both dated October 1, 1994, indicated the snacks are displayed on a cart and circulated to the residents' rooms by the nursing staff. The nurses aide asks each resident which snack they would care for, after checking the resident's diet order and/or allergies. It is the responsibility of the charge nurse to ensure nourishments are distributed to the residents. Assist the resident as necessary. If the resident is in the activity room, the staff are to take their nourishment to them, and assist them if needed.

A review of the facility's Investigation Record dated October 3, 2014, at 9 a.m., indicated CNA 1 saw Resident 1 walking with her walker to the nourishment cart in the hallway. Resident 1 began picking up multiple food items from the cart and placed them into a plastic bag. CNA 1 was standing on the opposite side of the nourishment cart facing Resident 1, when the resident suddenly

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	fell backwards hitting the back of her head. The Charge Nurse Narrative Notes regarding the incident dated October 2, 2014, indicated at 6:30 p.m., Resident 1 was seen ambulating with her walker heading towards the nourishment cart near Room 123. Resident 1 approached the cart on the opposite side, started picking up multiple items from the cart to place into a plastic bag hanging on her FWW. Resident 1 let go of the walker in order to place the items into her bag. While doing so she lost her balance and fell backwards hitting the back of her head on the floor. CNA 1 ran to the other side of the cart, and the resident was unresponsive for approximately two minutes. Nursing staff were notified and responded immediately. Vital signs were checked and 911 called. At 6: 35 p.m., the paramedics arrived, assessed the resident who remained unmoved, awake but altered in mental status. Resident was not able to answer any questions, and had an episode of vomiting. The paramedics transferred Resident 1 to the GACH. A review of the GACH Emergency Room Report dated October 2, 2014, indicated Resident 1 arrived at the emergency room at 7:11 p.m. Resident 1 was assessed in emergency with an altered level of consciousness with an acute brain injury. Resident 1 was intubated (the process of inserting a tube through the mouth and into the airway to enable the use of a breathing machine to assist with breathing when unable to breath independently). Resident 1 had an elevated systolic blood pressure of 260 (reference range 120), with no movement to all extremities. A brain scan revealed a large left			

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	subdural hematoma (a collection of blood outside the brain usually caused by severe head bleeding and increased pressure on the brain and can be life-threatening) with midline shift, mass effect and evidence of herniation (a potentially deadly side effect of very high intracranial pressure that occurs when a part of the brain is squeezed across the brain structures). The ER report indicated Resident 1 had an extremely poor prognosis (outcome) consistent with brain death at 8:27 p.m., and there were no further interventions needed to preserve the neurological functions. Resident 1 died the same date she was admitted to the GACH, October 2, 2014, at 10:27 p.m. A review of the Certificate of Death dated October 2, 2014, indicated the following: 1. Immediate Cause of Death: (a) Subdural Hematoma [is a collection of blood is a collection of blood between the covering of the brain (dura) and the surface of the brain, usually caused by severe head injuries] (b) Blunt Force Head Injury. 2. Other Significant conditions contributing to death but not resulting in the underlying cause: Hypertension, Cerebral Vascular Accident. The above violations, jointly, separately or in any combination, presented either an imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result, and were a direct proximate cause of death of Resident 1.			