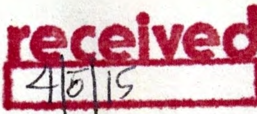
State of California - Health and Human Services Agency



Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 94-2275-0011362-F

Date: 03/31/2015 Time: 3:26pm

Type of Visit : Complaint Investig.

Incident/Complaint No.(s) : No complaints found

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

Licensee Name:	Vernon Healthcare Center, LLC		
Address:	1037 W. Vernon Avenue	Los Angeles, CA 90037	
License Number:	970000025	Type of Ownership:	Limited Liability Company

Facility Name:	VERNON HEALTHCARE CENTER	
Address:	1037 W Vernon Ave Los Angeles, CA 90037	
Telephone:	(323) 232-4895	
Facility Type:	Skilled Nursing Facility	Capacity: 99
Facility ID:	970000050	

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $20,000.00	DEADLINE FOR COMPLIANCE 3/31/15 11:59 p.m.

F279
F323

CLASS A CITATION -- PATIENT CARE

F279 - 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.

F323 - 42 CFR 483.25 (h)(2). Accidents. The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

The facility failed to provide Resident 1 who was identified to be a high risk for falls, a safe environment that minimized complications associated with falls, and develop a plan of care that included the provision of a low bed, a bed alarm and placement of a mattress on the floor (a landing pad) beside the bed, according to the facility's policy and procedure for falls.

These violations resulted in Resident 1's fall, sustaining a brain hematoma (a localized swelling filled with blood) with altered level of consciousness and grand mal seizure (a loss of consciousness and violent muscle contractions). Consequently, Resident 1 was transferred to the hospital for treatment. Resident 1 was admitted at the hospital for 10 days and was discharged to another skilled nursing facility under hospice care. Resident 1 died at the skilled nursing facility 10 days after discharge from the hospital.

Name of Evaluator:
Fely Magallanes
HFEN

For Fely Magallanes:

Evaluator Signature : [signature]

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

Signature : [signature]

Name : Alexis Washington

Title : NHA

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

A review of Resident 1's clinical record indicated he was admitted on 11/12/12 and was readmitted to the facility on 1/21/13. Resident 1's diagnoses included difficulty in walking, history of right-sided CVA (cerebrovascular accident or stroke) with aphasia (a loss or impairment of the ability to produce and/or comprehend language, due to brain damage), generalized weakness, dementia (a progressive loss of brain function affecting memory, thinking, and behavior), and encephalopathy (a disease of the brain that alters brain function or structure).

A review of Resident 1's care plan for falls, dated 11/15/12, indicated risk factors that included limited mobility, poor balance, decreased mental ability, decreased ability to communicate, unsteady when walking, and lack of awareness. The fall care plan's goal included Resident 1 would minimize his risk for fall through interventions. There was no documented evidence of interventions or measures established to address Resident 1's risk factors to prevent a fall and minimize injuries.

A review of the Physician Orders for Life-Sustaining Treatment (POLST), dated 1/24/13, indicated Resident 1 was to receive CPR (cardiopulmonary resuscitation) if he has no pulse and is not breathing and full treatment if he has a pulse or he is breathing.

The Minimum Data Set (MDS, an assessment and care screening tool), dated 5/20/13, indicated Resident 1 had long-term and short-term memory problems, required extensive assistance (staff provided weight bearing support and at times required full staff performance) to total assistance for bed mobility, transfer, ambulation, dressing, and personal hygiene and was incontinent (had no control) of bowel and bladder.

A review of the "Fall Risk Assessment Form," dated 1/21/13, and 4/21/13, indicated Resident 1 had a high risk for falls.

A review of the physician's order, dated 2/25/13, indicated for Resident 1 to have sheep skin padded cover on the bed side rails to protect the skin due to episodes of getting out of bed unassisted. However, Resident 1's care plan for falls , dated 11/15/12 was not updated to reflect Resident 1's behavior of getting out of bed unassisted (additional risk factor).

A review of the Nurses' Progress Notes, dated 5/19/13, at 10:45 p.m., indicated a certified nursing assistant (CNA) heard a noise from Resident 1's room and found Resident 1 sitting on the floor next to his bed. Resident 1 had his back leaning against the bed and was facing the wall. Resident 1 was assessed by a licensed nurse, who

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

indicated Resident 1 had not sustained any injuries. Resident 1 was assisted back to bed by two CNAs.

A review of the 72 Hour Neuro (neurological) Check List (a form indicating a pre-printed time schedule on how often the neurological checks were to be done) indicated Resident 1's blood pressure, level of consciousness, and pupils (the circle in the middle of the eye) signs were monitored every 30 minutes two times (on 5/19/13 at 10:45 p.m. and 11:15 p.m.) and every hour three times (on 5/20/13 at 12:15 a.m., 1:15 a.m., and 2:15 a.m.).

The 72 Hour Neuro Check List indicated from 5/19/13 at 10:45 p.m. thru 5/20/13 at 2:15 a.m., Resident 1's systolic blood pressure (the top number in the blood pressure, which measures the pressure in the arteries when the heart beats) was between 128-136 mmHg (millimeters of mercury); the diastolic blood pressure (the bottom number, which measures the pressure in the arteries between heartbeats) was between 70-76 mmHg; he was alert (level of consciousness); and his pupils were equal and responsive (to light). The next scheduled neuro check was on 5/20/13 at 4:15 a.m.

The Nurses Notes, dated 5/20/13, at 4 a.m., indicated Resident 1 had a change of condition. Resident 1 was observed to be shaking (while on the bed) and his vital signs consisted of blood pressure [(BP) the pressure exerted by the circulating volume of blood on the walls of the arteries] was measured at 150/112 mmHg (normal reference range is less than 120/80 mmHg), heart rate was 160 beats per minute (normal reference range from 60 to 100 beats per minute), respirations were 22 breaths per minute (normal reference range for an adult person at rest range from 12 to 16 breaths per minute), and temperature was 101 degrees Fahrenheit (normal reference range from 97.8 degrees F to 99 degrees F). The physician was notified at 4:02 a.m. and Resident 1 was transferred at 4:08 a.m. to the hospital via paramedics.

A review of the hospital's "Emergency Department (ED) Medical Chart," dated 5/20/13, indicated Resident 1 arrived in the ED due to seizure and hypotension (abnormal low blood pressure). The ED Medical Chart indicated that on 5/20/13 at 4:38 a.m., Resident 1 had a tonic clonic seizure (formerly known as grand mal seizure, a type of generalized seizure that affects the entire brain) in the nursing home, post ictal (the altered state of consciousness after a seizure) with EMS (emergency medical services), and was given Versed (a drug that causes relaxation, sleepiness and can cause a partial or complete loss of memory during the use of the drug) en route (to the hospital).

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

The ED Medical Chart indicated Resident 1 was placed on Trendelenburg position (head lower than feet) due to BP of 64/46 mmHg, Dilantin 1 gram (an antiseizure medication) was given intravenously (IV, directly into a vein), and a bolus (a dose) of 500 cubic centimeter (cc) 0.9 percent (%) normal saline (salt solution) was given via IV, and the resident was transferred to the intensive care unit (ICU) for close observation.

A review of the History and Physical from the acute hospital, dated 5/20/13, indicated Resident 1 did not have any prior seizure. The resident's physical examination indicated he was not alert and not oriented, and only responded to pain simulation.

A review of the CT Scan (computed tomography [CT] scan uses x-rays to make detailed pictures of structures inside of the body) of the head, dated 5/20/13, indicated "Impression: There is a 2 cm (centimeter) intraparenchymal hemorrhage (bleeding in the brain parenchyma [the main part of the brain]) in the left frontal lobe. There is an adjacent 8 cm wide x 4 cm in length subdural hematoma (a collection of blood on the surface of the brain and is usually the result of a serious head injury) at the left frontal region. The above is new in comparison to the prior study on March 3rd, 2011. There is opacification of the sphenoid sinus (means that there is material such as blood or mucus that is filling the sphenoid sinus that is located behind the nose and eyes), new from the prior study."

The neurologist consultation report, dated 5/20/13, indicated the reason for consultation was the left frontal intraparehnchymal hemorrhage of Resident 1. The physical examination section of the report indicated "...There is no external evidence of head trauma. There are Battle signs (bruising which appears on the surface of the skin and is caused by the escape of blood into the tissues from ruptured blood vessels and the bruising appears behind one or both ears) or raccoon eyes (refers to a dark purple discoloration forming around the eyes, giving an appearance similar to that of a raccoon) ..."

The neurologist consultation report also indicated Resident 1's hemorrhage was without mass effect (the effect of a growing mass that results in secondary pathological effects by pushing on or displacing surrounding tissue) or midline shift (shift of the brain past the center line which can indicate problems such as intracranial [inside the skull] pressure).

A review of Resident 1's MRI (magnetic resonance imaging, a test that uses magnetic and radio waves to take detailed pictures of organs and other structures inside the body) of the brain, which was performed to rule out underlying mass, dated 5/21/13,

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	indicated Resident 1 had bleeding in his brain and had several hematomas: left front brain, subdural (on the surface) both sides, and deep in his brain. The MRI report also indicated that the dense material in the sphenoid sinus is possibly representing blood. The gastroenterologist undated consultation report conducted due to Resident 1's feeding difficulty, indicated the resident was evaluated by both Neurology and Neurosurgery and the plan was to provide conservative care. The gastroenterologist consultation report also indicated Resident 1 was unable to swallow for the last 24 to 36 hours and the gastrostomy tube placement (also known as a feeding tube, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) was deferred for the next few days to assess the resident's improvement in his mental status as recommended by the neurologist. The resident had a nasogastric (through the nose and down into the stomach) tube feeding in the interim. A review of the physician's order, dated 5/29/13 and timed at 11:50 a.m., indicated Resident 1 was to be DNR (do not resuscitate) and to provide the resident with comfort measures (any action taken to promote the soothing of a patient, such as a back rub, a change in position, administration of selected medications or treatments) only. A review of the physician's progress record, dated 5/29/13 and timed 1:45 p.m., indicated "family has elected for comfort care measures & hospice (a philosophy of care that recognizes death as a natural part of life and seeks neither to prolong nor hasten the dying process) & no PEG (percutaneous endoscopic gastrostomy, a type of feeding tube) or other interventions." According to the Discharge Summary from the hospital, dated 5/30/13, during the hospitalization, Resident 1 had an EEG (electroencephalogram, a test that detects electrical activity in your brain using small, flat metal discs or electrodes attached to your scalp) done and the result was consistent with seizure. The discharge summary report indicated Resident 1 was transferred to hospice as requested by the family. Resident 1's discharge diagnoses were status post intracranial hemorrhage, subdural hematoma, dementia, history of stroke, and seizure disorder. A review of the physician order (from the hospital), dated 5/30/13, indicated to discharge Resident 1 to a skilled nursing facility with hospice care. Resident 1 went to another skilled nursing facility where he died on 6/9/13, 10 days after being discharged

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	from the hospital. A review of Resident 1's death certificate indicated he died on 6/9/13 in a skilled nursing facility, his death was not reported to a coroner, autopsy was not performed, and the immediate cause of his death was cardiac arrest. The underlying cause (disease or injury that initiated the events resulting in death) were multiple organ failure and cerebral vascular disease (a group of brain dysfunctions related to disease of the blood vessels supplying the brain). Other significant conditions contributing to his death but not resulting in the underlying cause were dementia, seizures, and stroke. On 2/11/14, at 1:45 p.m., during an interview, the licensed vocational nurse (LVN 1) stated Resident 1 was not provided with floor mattress and alarm in the bed prior to his fall on 5/19/13. On 2/11/14, at 2 p.m., during an interview, the MDS coordinator stated she did not see any floor mattress beside Resident 1's bed and no alarm in the bed prior to Resident 1's fall on 5/19/13. On 2/11/14, at 2:30 p.m., the director of nursing (DON) reviewed Resident 1's fall care plan. After reviewing Resident 1's fall care plan, the DON stated, during an interview, there should have been interventions or measures established in the fall care plan for Resident 1 prior to his fall on 5/19/13. The DON stated, while reviewing Resident 1's fall care plan, that at the time of the fall, the height of Resident 1's bed was not in the low position, there was no floor mattress beside his bed and there was no alarm in the bed. The DON stated there were no fall precautions for Resident 1. On 2/11/14, at 3 p.m., during an interview, LVN 2 stated she did not see any floor mattress beside Resident 1's bed and there was no alarm in his bed on 5/19/13. On 2/11/14 at 3:15 p.m., during an interview, CNA 1 stated on the night of 5/19/13, she heard a loud noise, went to Resident 1's room, and found Resident 1 facing the wall while sitting on the floor. She stated there was no alarm on Resident 1's bed and she could not remember seeing any floor mattress beside his bed. During an observation with CNA 1, on 1/22/15 at 3:20 p.m., the space between the bed previously occupied by Resident 1 and the wall was about an arm's length. On 2/11/14 at 4 p.m., during an interview, CNA 2 stated when he saw Resident 1 on the floor on 5/19/13, he did not see any alarm on Resident 1's bed and he could not

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	remember seeing any floor mattress beside his bed.

On 1/23/15 at 10:45 a.m., during an interview, Physician 1 (the facility's Medical Director and Resident 1's primary physician on 5/19/13) stated always assume that a fall occurred when a resident is found sitting on the floor. In the case of Resident 1, who had an unwitnessed fall, had no evidence of external trauma to the head, but had developed a bleed on the frontal lobe of his brain, Physician 1 stated without an autopsy, it would be hard to confirm the cause of the bleed.

A review of the facility's policy and procedure titled, "Fall prevention and Management Program," revised 12/1/12, indicated to provide a safe environment that minimizes complications associated with falls. The licensed nurse and/or interdisciplinary team (IDT, a group consisting of the head of the different departments who work together to discuss a resident's care) will develop a plan of care according to the identified risk factors and root cause.

Therefore, the facility failed to provide Resident 1 who was identified to be a high risk for falls, a safe environment that minimized complications associated with falls, and develop a plan of care that included the provision of a low bed, a bed alarm and placement of a mattress on the floor (a landing pad) beside the bed, according to the facility's policy and procedure for falls.

These violations resulted in Resident 1's fall, sustaining a brain hematoma (a localized swelling filled with blood) with altered level of consciousness and grand mal seizure (a loss of consciousness and violent muscle contractions). Consequently, Resident 1 was transferred to the hospital for treatment. Resident 1 was admitted at the hospital for 10 days and was discharged to another skilled nursing facility under hospice care. Resident 1 died at the skilled nursing facility 10 days after discharge from the hospital.

This failure presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result.

POC reviewed & accepted 3/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055167	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 12/02/2014
NAME OF PROVIDER OR SUPPLIER: **VERNON HEALTHCARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE: **1037 W Vernon Ave, Los Angeles, CA 90037-2415 LOS ANGELES 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 A CITATION -- PATIENT CARE 94-2275-0011362-F Complaint(s): No complaints found Representing the Department of Public Health: Surveyor ID # 27812, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. F279 - 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. F323 - 42 CFR 483.25 (h)(2). Accidents. The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. The facility failed to provide Resident 1 who was identified to be a high risk for falls, a safe environment that minimized complications associated with falls, and develop a plan of care that included the provision of a low bed, a bed alarm and placement of a mattress on the floor (a landing pad) beside the bed, according to the facility's policy and procedure for falls.		*Vernon Healthcare Center 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 or 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.* **Corrective action for residents found to have been affected by this deficiency:** Resident 1 is no longer at the facility. He was discharged to acute hospital on 5/20/13	**05/20/13**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alexis Washington TITLE: NHA (X6) DATE: 3-31-15

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 12

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. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055167	A. BUILDING ______ B. WING ______	12/02/2014

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	These violations resulted in Resident 1's fall, sustaining a brain hematoma (a localized swelling filled with blood) with altered level of consciousness and grand mal seizure (a loss of consciousness and violent muscle contractions). Consequently, Resident 1 was transferred to the hospital for treatment. Resident 1 was admitted at the hospital for 10 days and was discharged to another skilled nursing facility under hospice care. Resident 1 died at the skilled nursing facility 10 days after discharge from the hospital.		**Corrective action for residents that maybe affected by this deficiency:** On 12/12/14, the IDT reviewed and revised other residents at high risk for fall to ensure that resident's specific care needs are properly addressed.	**12/12/14**
	A review of Resident 1's clinical record indicated he was admitted on 11/12/12 and was readmitted to the facility on 1/21/13. Resident 1's diagnoses included difficulty in walking, history of right-sided CVA (cerebrovascular accident or stroke) with aphasia (a loss or impairment of the ability to produce and/or comprehend language, due to brain damage), generalized weakness, dementia (a progressive loss of brain function affecting memory, thinking, and behavior), and encephalopathy (a disease of the brain that alters brain function or structure).		**Measures that will be put into place to ensure that this deficiency does not recur:** On 12/12/14 The DSD, DNS and/or Nurse Consultant, re-educated the IDT on developing interdisciplinary care plans reflective of individual needs of the residents and review and revision at minimum quarterly, annually, change of condition and as needed basis.	**12/12/14**
			The IDT will develop, review and revise the resident's plan of care upon admission, quarterly, annually; change of condition according to the resident's identified needs.	**Ongoing**
	A review of Resident 1's care plan for falls, dated 11/15/12, indicated risk factors that included limited mobility, poor balance, decreased mental ability, decreased ability to communicate, unsteady when walking, and lack of awareness. The fall care plan's goal included Resident 1 would minimize his risk for fall through interventions. There was no documented evidence of interventions or measures established to address Resident 1's risk factors to		The MRD on a monthly basis will conduct care plan QA reviews to determine the IDT compliance on developing interdisciplinary care plans reflective of individual needs of the residents and review and revision at minimum quarterly, annually, change of condition and as needed basis.	**Monthly**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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prevent a fall and minimize injuries.

A review of the Physician Orders for Life-Sustaining Treatment (POLST), dated 1/24/13, indicated Resident 1 was to receive CPR (cardiopulmonary resuscitation) if he has no pulse and is not breathing and full treatment if he has a pulse or he is breathing.

The Minimum Data Set (MDS, an assessment and care screening tool), dated 5/20/13, indicated Resident 1 had long-term and short-term memory problems, required extensive assistance (staff provided weight bearing support and at times required full staff performance) to total assistance for bed mobility, transfer, ambulation, dressing, and personal hygiene and was incontinent (had no control) of bowel and bladder.

A review of the "Fall Risk Assessment Form," dated 1/21/13, and 4/21/13, indicated Resident 1 had a high risk for falls.

A review of the physician's order, dated 2/25/13, indicated for Resident 1 to have sheep skin padded cover on the bed side rails to protect the skin due to episodes of getting out of bed unassisted. However, Resident 1's care plan for falls , dated 11/15/12 was not updated to reflect Resident 1's behavior of getting out of bed unassisted (additional risk factor).

A review of the Nurses' Progress Notes, dated 5/19/13, at 10:45 p.m., indicated a certified nursing assistant (CNA) heard a noise from Resident 1's

F-323

Immediate Corrective Action:
Resident 1 is no longer a resident of the facility. He was discharged to an acute hospital on 5/20/2013. — **05/20/13**

Identification of other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:
The IDT will review other residents at risk for fall by 12/12/2014 and their plan of care will be reviewed and revised accordingly. — **12/12/14**

Measures to be put in place to prevent recurrence of the deficient practice:
By 12/12/14, the Nurse Consultant, Director of Nursing Services (DNS) and or Director of Staff Development (DSD) will re- educate licensed nurses and CNAs on facility's accident incident prevention policy and procedures emphasizing on establishing fall care plan with interventions addressing the resident's risk factors to prevent a fall according to the facility's policy and procedure. — **12/12/14**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	room and found Resident 1 sitting on the floor next to his bed Resident 1 had his back leaning against the bed and was facing the wall. Resident 1 was assessed by a licensed nurse, who indicated Resident 1 had not sustained any injuries. Resident 1 was assisted back to bed by two CNAs. A review of the 72 Hour Neuro (neurological) Check List (a form indicating a pre-printed time schedule on how often the neurological checks were to be done) indicated Resident 1's blood pressure, level of consciousness, and pupils (the circle in the middle of the eye) signs were monitored every 30 minutes two times (on 5/19/13 at 10:45 p.m. and 11:15 p.m.) and every hour three times (on 5/20/13 at 12:15 a.m., 1:15 a.m., and 2:15 a.m.). The 72 Hour Neuro Check List indicated from 5/19/13 at 10:45 p.m. thru 5/20/13 at 2:15 a.m., Resident 1's systolic blood pressure (the top number in the blood pressure, which measures the pressure in the arteries when the heart beats) was between 128-136 mmHg (millimeters of mercury); the diastolic blood pressure (the bottom number, which measures the pressure in the arteries between heartbeats) was between 70-76 mmHg; he was alert (level of consciousness); and his pupils were equal and responsive (to light). The next scheduled neuro check was on 5/20/13 at 4:15 a.m. The Nurses Notes, dated 5/20/13, at 4 a.m., indicated Resident 1 had a change of condition. Resident 1 was observed to be shaking (while on the bed) and his vital signs consisted of blood		By 12/12/14, the Nurse Consultant, Director of Nursing Services (DNS) and or Director of Staff Development (DSD) will re- educate IDT on facility's accident incident prevention policy and procedures emphasizing the need to analyze the root cause, develop appropriate interventions, monitor for effectiveness and if needed, revise and/ or escalate interventions to prevent further falls. Resident's high risk for falls will have their special needs sheet updated by the LN and/or IDT on a daily basis to reflect that the resident is high risk for fall. The Licensed nurses and CNAs utilizing the special needs sheet will monitor and ensure interventions are implemented and documented. By 12/12/14, the Nurse Consultant, Director of Nursing Services (DNS) and or Director of Staff Development (DSD) will educate the C.N.A's Licensed Nurses and the IDT on the use of special needs sheet to facilitate recognition of resident who are high risk for fall. The Licensed nurses and Department Managers will utilize the list to monitor those residents for compliance during their regular observation rounds.	**12/12/14** **Ongoing** **12/12/14**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055167	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON HEALTHCARE CENTER	1037 W Vernon Ave, Los Angeles, CA 90037-2415 LOS ANGELES COUNTY

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	pressure [(BP) the pressure exerted by the circulating volume of blood on the walls of the arteries] was measured at 150/112 mmHg (normal reference range is less than 120/80 mmHg), heart rate was 160 beats per minute (normal reference range from 60 to 100 beats per minute), respirations were 22 breaths per minute (normal reference range for an adult person at rest range from 12 to 16 breaths per minute), and temperature was 101 degrees Fahrenheit (normal reference range from 97.8 degrees F to 99 degrees F). The physician was notified at 4:02 a.m. and Resident 1 was transferred at 4:08 a.m. to the hospital via paramedics. A review of the hospital's "Emergency Department (ED) Medical Chart," dated 5/20/13, indicated Resident 1 arrived in the ED due to seizure and hypotension (abnormal low blood pressure). The ED Medical Chart indicated that on 5/20/13 at 4:38 a.m., Resident 1 had a tonic clonic seizure (formerly known as grand mal seizure, a type of generalized seizure that affects the entire brain) in the nursing home, post ictal (the altered state of consciousness after a seizure) with EMS (emergency medical services), and was given Versed (a drug that causes relaxation, sleepiness and can cause a partial or complete loss of memory during the use of the drug) en route (to the hospital). The ED Medical Chart indicated Resident 1 was placed on Trendelenburg position (head lower than feet) due to BP of 64/46 mmHg, Dilantin 1 gram (an antiseizure medication) was given intravenously (IV,		The Department Managers and the Licensed Nurses will monitor for compliance during every shift QI Observation Rounds. Findings will be reported to the Administrator and DNS for appropriate corrective actions. **Monitoring performance to ensure that correction is achieved and sustained:** The Administrator will provide a summary trend analysis of the findings to the facility's monthly CQI Steering committee for further review, evaluations and recommendations.	**Ongoing** **Monthly**

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directly into a vein), and a bolus (a dose) of 500 cubic centimeter (cc) 0.9 percent (%) normal saline (salt solution) was given via IV, and the resident was transferred to the intensive care unit (ICU) for close observation.

A review of the History and Physical from the acute hospital, dated 5/20/13, indicated Resident 1 did not have any prior seizure. The resident's physical examination indicated he was not alert and not oriented, and only responded to pain simulation.

A review of the CT Scan (computed tomography [CT] scan uses x-rays to make detailed pictures of structures inside of the body) of the head, dated 5/20/13, indicated "Impression: There is a 2 cm (centimeter) intraparenchymal hemorrhage (bleeding in the brain parenchyma [the main part of the brain]) in the left frontal lobe. There is an adjacent 8 cm wide x 4 cm in length subdural hematoma (a collection of blood on the surface of the brain and is usually the result of a serious head injury) at the left frontal region. The above is new in comparison to the prior study on March 3rd, 2011. There is opacification of the sphenoid sinus (means that there is material such as blood or mucus that is filling the sphenoid sinus that is located behind the nose and eyes), new from the prior study."

The neurologist consultation report, dated 5/20/13, indicated the reason for consultation was the left frontal intraparehnchymal hemorrhage of Resident 1. The physical examination section of the report indicated "...There is no external evidence of head trauma. There are Battle signs (bruising which

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appears on the surface of the skin and is caused by the escape of blood into the tissues from ruptured blood vessels and the bruising appears behind one or both ears) or raccoon eyes (refers to a dark purple discoloration forming around the eyes, giving an appearance similar to that of a raccoon) ..."

The neurologist consultation report also indicated Resident 1's hemorrhage was without mass effect (the effect of a growing mass that results in secondary pathological effects by pushing on or displacing surrounding tissue) or midline shift (shift of the brain past the center line which can indicate problems such as intracranial [inside the skull] pressure).

A review of Resident 1's MRI (magnetic resonance imaging, a test that uses magnetic and radio waves to take detailed pictures of organs and other structures inside the body) of the brain, which was performed to rule out underlying mass, dated 5/21/13, indicated Resident 1 had bleeding in his brain and had several hematomas: left front brain, subdural (on the surface) both sides, and deep in his brain. The MRI report also indicated that the dense material in the sphenoid sinus is possibly representing blood.

The gastroenterologist undated consultation report conducted due to Resident 1's feeding difficulty, indicated the resident was evaluated by both Neurology and Neurosurgery and the plan was to provide conservative care.

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The gastroenterologist consultation report also indicated Resident 1 was unable to swallow for the last 24 to 36 hours and the gastrostomy tube placement (also known as a feeding tube, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) was deferred for the next few days to assess the resident's improvement in his mental status as recommended by the neurologist. The resident had a nasogastric (through the nose and down into the stomach) tube feeding in the interim.

A review of the physician's order, dated 5/29/13 and timed at 11:50 a.m., indicated Resident 1 was to be DNR (do not resuscitate) and to provide the resident with comfort measures (any action taken to promote the soothing of a patient, such as a back rub, a change in position, administration of selected medications or treatments) only.

A review of the physician's progress record, dated 5/29/13 and timed 1:45 p.m., indicated "family has elected for comfort care measures & hospice (a philosophy of care that recognizes death as a natural part of life and seeks neither to prolong nor hasten the dying process) & no PEG (percutaneous endoscopic gastrostomy, a type of feeding tube) or other interventions."

According to the Discharge Summary from the hospital, dated 5/30/13, during the hospitalization, Resident 1 had an EEG (electroencephalogram, a test that detects electrical activity in your brain using small, flat metal discs or electrodes attached

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to your scalp) done and the result was consistent with seizure. The discharge summary report indicated Resident 1 was transferred to hospice as requested by the family. Resident 1's discharge diagnoses were status post intracranial hemorrhage, subdural hematoma, dementia, history of stroke, and seizure disorder.

A review of the physician order (from the hospital), dated 5/30/13, indicated to discharge Resident 1 to a skilled nursing facility with hospice care. Resident 1 went to another skilled nursing facility where he died on 6/9/13, 10 days after being discharged from the hospital.

A review of Resident 1's death certificate indicated he died on 6/9/13 in a skilled nursing facility, his death was not reported to a coroner, autopsy was not performed, and the immediate cause of his death was cardiac arrest. The underlying cause (disease or injury that initiated the events resulting in death) were multiple organ failure and cerebral vascular disease (a group of brain dysfunctions related to disease of the blood vessels supplying the brain). Other significant conditions contributing to his death but not resulting in the underlying cause were dementia, seizures, and stroke.

On 2/11/14, at 1:45 p.m., during an interview, the licensed vocational nurse (LVN 1) stated Resident 1 was not provided with floor mattress and alarm in the bed prior to his fall on 5/19/13.

On 2/11/14, at 2 p.m., during an interview, the MDS coordinator stated she did not see any floor

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mattress beside Resident 1's bed and no alarm in the bed prior to Resident 1's fall on 5/19/13.

On 2/11/14, at 2:30 p.m., the director of nursing (DON) reviewed Resident 1's fall care plan. After reviewing Resident 1's fall care plan, the DON stated, during an interview, there should have been interventions or measures established in the fall care plan for Resident 1 prior to his fall on 5/19/13. The DON stated, while reviewing Resident 1's fall care plan, that at the time of the fall, the height of Resident 1's bed was not in the low position, there was no floor mattress beside his bed and there was no alarm in the bed. The DON stated there were no fall precautions for Resident 1.

On 2/11/14, at 3 p.m., during an interview, LVN 2 stated she did not see any floor mattress beside Resident 1's bed and there was no alarm in his bed on 5/19/13.

On 2/11/14 at 3:15 p.m., during an interview, CNA 1 stated on the night of 5/19/13, she heard a loud noise, went to Resident 1's room, and found Resident 1 facing the wall while sitting on the floor. She stated there was no alarm on Resident 1's bed and she could not remember seeing any floor mattress beside his bed. During an observation with CNA 1, on 1/22/15 at 3:20 p.m., the space between the bed previously occupied by Resident 1 and the wall was about an arm's length.

On 2/11/14 at 4 p.m., during an interview, CNA 2 stated when he saw Resident 1 on the floor on 5/19/13, he did not see any alarm on Resident 1's

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bed and he could not remember seeing any floor mattress beside his bed.

On 1/23/15 at 10:45 a.m., during an interview, Physician 1 (the facility's Medical Director and Resident 1's primary physician on 5/19/13) stated always assume that a fall occurred when a resident is found sitting on the floor. In the case of Resident 1, who had an unwitnessed fall, had no evidence of external trauma to the head, but had developed a bleed on the frontal lobe of his brain, Physician 1 stated without an autopsy, it would be hard to confirm the cause of the bleed.

A review of the facility's policy and procedure titled, "Fall prevention and Management Program," revised 12/1/12, indicated to provide a safe environment that minimizes complications associated with falls. The licensed nurse and/or interdisciplinary team (IDT, a group consisting of the head of the different departments who work together to discuss a resident's care) will develop a plan of care according to the identified risk factors and root cause.

Therefore, the facility failed to provide Resident 1 who was identified to be a high risk for falls, a safe environment that minimized complications associated with falls, and develop a plan of care that included the provision of a low bed, a bed alarm and placement of a mattress on the floor (a landing pad) beside the bed, according to the facility's policy and procedure for falls.

These violations resulted in Resident 1's fall,

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	sustaining a brain hematoma (a localized swelling filled with blood) with altered level of consciousness and grand mal seizure (a loss of consciousness and violent muscle contractions). Consequently, Resident 1 was transferred to the hospital for treatment. Resident 1 was admitted at the hospital for 10 days and was discharged to another skilled nursing facility under hospice care. Resident 1 died at the skilled nursing facility 10 days after discharge from the hospital. This failure presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result.			