State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 11-2707-0012905-F

Date: 02/28/2017 Time: 11:47 am

Type of Visit :

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

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

Licensee Name: Eureka Rehabilitation & Wellness Center, LP

Address: 2353 23rd Street Eureka, CA 95501

License Number: 010000054 Type of Ownership: Partnership

Facility Name: Eureka Rehab & Wellness Center, LP

Address: 2353 23rd St Eureka, CA 95501

Telephone:

Facility Type: Skilled Nursing Facility Capacity: 99

Facility ID: 010000078

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F520

CLASS A **CITATION -- ADMINISTRATION**

F-520 §483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS

(g) Quality assessment and assurance.

(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:

(i) The director of nursing services;

(ii) The Medical Director or his/her designee;

(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and

(g)(2) The quality assessment and assurance committee must:

(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and

Name of Evaluator:

Clara Wu
HFEN

James Shannon HFEN

Evaluator Signature : James Shannon

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

Signature : Dana Alan

Name : Dana A. Webb

Title : Administrator

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

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	(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. The facility's quality assessment and assurance committee (QAA) failed to: 1. Develop formal corrective action plans or implement the action plans to prevent falls, which caused harm to residents as evidenced by: The facility did not provide adequate supervision and assistance, revise fall risk care plans and implement the care plans, follow fall protocol for post-fall assessment and management to prevent falls and injuries for Residents 1, 2, 3, 4, 5, 6, and 14 when: a. Resident 1 walked to the restroom unassisted, grabbed the rod across the restroom entrance and fell on the floor on 8/28/16. This caused Resident 1 to sustain a left humeral neck (upper arm bone just under the shoulder joint) fracture which required admission to an acute care hospital for treatment. b. Resident 2 had five falls during a one month period from 8/12/16 to 9/14/16. Resident 2 sustained a head injury from the last fall on 9/14/16, which required Resident 2 to be sent to an acute care hospital for evaluation and treatment. After 9/14/16, Resident 2 had three more falls on 10/26/16, 11/5/16, and 11/26/16. c. Staff did not follow their fall protocol for post-fall assessment and notify the physician of a fall when Resident 3 reported having fallen on 10/20/16. This resulted in Resident 3 not being evaluated after the fall until 10/25/16 (five days later). d. Resident 5 had six falls during a six and one-half months period from 5/24/16 to 12/6/16. On 5/24/16, Resident 5 fell and sat on the floor in the bathroom which was wet with urine. A fall on 11/23/16, resulted in Resident 5 sustaining a small skin tear on the top ridge of the nose on 11/23/16 at 9:35 p.m. (This was the second fall that day). e. Resident 4 had three falls during a one-month period from 8/16/16 to 9/17/16.

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Resident 4 sustained a skin tear on the right hand from a fall on 8/16/16, and re-opened a skin tear on the right hand from a fall on 8/21/16. Resident 4 had three more falls during a one-week period from 10/13/16 to 10/17/16, which resulted in a nasal bone (nose) fracture from a fall on 10/13/16.

f. Resident 6 had multiple falls in a six-month period from 5/22/16 to 11/25/16. Resident 6 sustained bleeding in the head from the fall on 8/1/16; a laceration (cut) on the left side of the head, which required eight staples from the fall on 10/13/16. Resident 6 sustained a laceration on the right side of the head from the fall on 11/25/16.

g. Licensed Staff did not revise Resident 14's (who had one unwitnessed fall on 11/4/16, which resulted in a skin tear to the left elbow and a fractured pelvis), "Fall Care Plan" to indicate Resident 14 was to be on, "one-on-one" with staff at all times starting 11/5/16, per physician's order. This failure to revise Resident 14's, "Fall Care Plan" had the potential for Resident 14 to fall again causing injury or even death.

2. Identify staffing issues and ensure sufficient nursing staff to provide quality resident care, which caused harm to their residents, as evidenced by resident falls and injuries (refer to 1a - 1g) and residents' care needs were not being met when call lights were not answered in a timely manner for Resident 17 and 18, and Resident 17's need of getting out of the bed earlier in the morning was not honored. These failures resulted in Resident 17 staying wet with the urine and feeing bad, and potentially compromised residents' physical and psychosocial well-being.

3. Communicate QAA minutes to the staff.

These failures also prevented the QAA committee from implementing and evaluating action plans to correct quality deficiencies and therefore was not able to determine effectiveness of changes to be implemented.

1a. Resident 1's admission record indicated Resident 1 was admitted to the facility on 1/22/16, with diagnoses including blindness both eyes, difficulty in walking, and generalized muscle weakness.

Resident 1's minimum data set (MDS, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 7/29/16, revealed a BIMS (Brief Interview for Mental Status) score of 14, which indicated Resident 1 was cognitively intact. The MDS

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	assessment indicated Resident 1 required limited assistance of one person with physical assistance for walking in the corridor and toilet use. The Fall Risk Assessment, dated 7/27/16, indicated Resident 1 was at high risk for falls due to multiple problems, including intermittent confusion, one to two falls in past three months, and being legally blind. Resident 1's care plan for fall risk prevention and management, initiated on 1/22/16 and re-evaluated on 7/16, indicated approaches for fall risk prevention and management including, "Orient resident to environment each time changes are made and provide an environment that supports minimized hazards over which the Facility has control..." The care plan did not specify how the facility would provide supervision to prevent Resident 1 from falling. Resident 1's care plan for visual impairment, initiated on 1/22/16, indicated, "Provide environment with items kept in consistent location, free from obstacles and clutter...uses handrails in hallway..." The care plan for activities of daily living, initiated on 1/22/16 and re-evaluated on 7/16, indicated Resident 1 required assistance for toilet use and personal hygiene. The Nurse's Note, dated 8/28/16, revealed Resident 1 had an unwitnessed fall at 9:10 a.m., when Resident 1 was ambulating to the restroom and walked onto wet floor sign. The IDT (Interdisciplinary Team) Conference Record, dated 8/29/16, indicated on 8/28/16, at 9:10 a.m., Resident 1 walked to the bathroom and stopped at the restroom doorway. Resident 1's hands grabbed the spring rod, which the housekeeper placed in the doorway for cleaning, and simultaneously leaned her weight backward expecting the rod to be stable like a handrail. Resident 1 fell to her left side and had left shoulder pain and left hip discomfort. Resident 1 was sent to an Emergency Department and admitted to an acute care hospital. The CT (Computerized Tomography, combines of X-ray images using computer process to create images) examination result, dated 8/28/16, and the History and Physical Report from the acute care hospital, dated 8/28/16, indicated Resident 1 sustained a non-operable left humeral neck (upper arm bone) fracture and was admitted to the hospital for pain control and evaluation. During an interview on 10/26/16 at 10:02 a.m., regarding Resident 1's fall on 8/28/16,

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	Licensed Staff A stated Resident 1 usually used the handrails in the hallway when Resident 1 was walking. Licensed Staff A stated Resident 1 had visual impairment. Resident 1 liked to grab the handrail and lean backward while talking to staff or other residents. Licensed Staff A stated on the day Resident 1 fell, Resident 1 walked to the restroom in the hallway and grabbed the spring rod, which the housekeeper placed in the doorway for cleaning. Licensed Staff A stated Resident 1 thought the rod was the handrail, so Resident 1 leaned her body backward while grabbing the rod. Licensed Staff A stated Resident 1 fell on the floor because the rod was not stable and fell off the doorway. Licensed Staff A stated no staff walked with Resident 1 because it was Resident 1's routine to walk to the restroom by herself using the handrails. Licensed Staff A stated the biggest mistake was lack of communication. Licensed Staff A stated the housekeeper did not tell her (Licensed Staff A) about placing the rod in the restroom doorway, otherwise she would have educated Resident 1 and let her feel the rod or walked with her. Licensed Staff A stated the rod was a new product, but they should not use it on the floor because it was dangerous. During an interview on 10/26/16, at 11:50 a.m., regarding Resident 1's fall on 8/28/16, Housekeeping Staff P stated she put the rod with a sign across the restroom doorway and two signs on the floor when she was mopping the restroom. Housekeeping Staff P stated she told Resident 1 the restroom was closed. Housekeeping Staff P stated after she cleaned the restroom, she left the rod with a sign across the restroom doorway and went to another hall. Housekeeping Staff P stated she did not tell Resident 1 that the rod was left in the doorway. Housekeeping Staff P stated she did not tell any staff about the rod because they could see it. Housekeeping Staff P stated from the beginning of using this type of rod, she told the Housekeeping Supervisor that the rod was terrible and not good for use because the rod did not have spring and was easy to fall off. She stated the rod was not stable and when people grabbed the rod, the rod fell. During a concurrent observation and interview on 10/26/16, at 11:25 a.m., in the Housekeeping Supervisor's office, Housekeeping Supervisor Q showed a yellow rod with a yellow sign, "CLOSED FOR CLEANING" hanging to the rod. Housekeeping Supervisor Q stated this was the rod with the sign Housekeeping Staff P used when she cleaned the restroom where Resident 1 fell. Housekeeping Supervisor Q stated the housekeeper put the rod across the doorway to indicate the room was being cleaned. Housekeeping Supervisor Q stated the housekeeper should tell the nurse when the rod was placed. Housekeeping Supervisor Q stated the rod was light metal and was not strong. Housekeeping Supervisor Q stated the facility had been using the rod for about six to seven months, but they did not have a policy and procedure regarding the use of

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the rod.

Upon request for the manufacturer's guidelines for the rod, Housekeeping Supervisor Q provided a page documentation titled, "FACILITY MAINTENANCE," undated, under A. Site Safety Hanging Sign, which did not indicate how to use the rod and sign safely.

1b. Resident 2's admission record indicated Resident 2 was re-admitted to the facility on 8/11/16, with diagnoses including Alzheimer's disease (a brain disease causing memory loss, impaired thinking and disorientation), dementia, and neuromuscular (relating to the nerves and muscles) dysfunction of bladder.

Resident 2's MDS assessment, dated 8/19/16, indicated Resident 2 was not able to complete the Brief Interview for Mental Status (BIMS). The MDS assessment indicated staff interview for mental status was conducted, and indicated Resident 2's cognitive skills for daily decision making was, "moderately impaired - decisions poor; cues/supervision required."

Resident 2's Fall Risk Evaluation, dated 8/12/16, indicated Resident 2 was at high risk for falls due to multiple problems including mental status, history of falls, ambulatory and elimination status, and gait/balance problems.

The care plan for fall risk prevention and management, initiated on 8/12/16, with approach started date 8/11/16, indicated approaches including, "Bed in low position, pad alarm (a device attached to the resident that triggers an alarm when the resident attempts to get up from the wheelchair or the bed) in bed..." The care plan did not specify how the facility would provide supervision to prevent Resident 2 from falling.

First Fall:

The Nurse's Note, dated 8/12/16 at 12 a.m., revealed Resident 2 had an unwitnessed fall in the his room. Resident 2 sustained a 3 cm X 3 cm skin tear with bruising at left elbow.

The care plan for the actual fall on 8/12/16, indicated a goal, "No serious injury from fall [for 7 days]." The approaches included observing and monitoring for 72 hours, mobility alarm, pads at bedside, and visual monitor just for one shift.

The IDT (Interdisciplinary Team) Conference Record, dated 8/12/16, regarding Resident

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2's fall on 8/12/16 at midnight, did not indicate new approaches to the fall risk care plan to prevent further falls. The fall risk care plan, initiated on 8/12/16, did not indicate new approaches and did not specify providing supervision to Resident 2 to prevent further falls.

Second Fall:

The Nurse's Note, dated 8/29/16, at 7 a.m., indicated nursing staff from the last two work shifts reported Resident 2 had a fall at 7:15 a.m., on 8/28/16. However, there were no documentation of Nurses' Notes on 8/28/16, regarding the fall.

The IDT Conference Record, dated 8/30/16, indicated Resident 2 had a fall with no injury on 8/28/16. The IDT note indicated to resume Risperdal (an antipsychotic medication, which works by changing the effects of chemicals in the brain), which was discontinued, due to increased agitation, re-emergence of aggressive verbal outbursts, pressured speech, and etc.

The care plan for the actual fall on 8/28/16, included to teach the new nurses on fall follow-up process and continue plan of care. The fall risk care plan, initiated on 8/12/16, did not indicate new approaches and did not specify providing supervision to Resident 2 to prevent further falls.

Third Fall:

The Nurse's Note, dated 9/5/16, at 4:20 p.m., indicated Resident 2 fell out from the wheelchair when he was watching TV in the TV room with other residents.

The IDT Conference Record, dated 9/6/16, regarding Resident 2's fall on 9/5/16, indicated Resident 2 had, "very poor safety awareness." The IDT determined to continue using the alarm with a goal, "no serious injury [with] fall." The IDT note did not specify providing supervision to Resident 2 to prevent further falls.

The care plan for the actual fall on 9/5/16, was to continue plan of care. The fall risk care plan initiated on 8/12/16, did not indicate new approaches and did not specify providing supervision to Resident 2 to prevent further falls.

Fourth Fall:

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	The Nurse's Note, dated 9/10/16, with unknown time of the note, indicated, "Am shift reports fall [with] no injury 10:30 Am..." The Nurse's Note did not describe how Resident 2 fell. The IDT Conference Record, dated 9/12/16, indicated Resident 2 stood up and fell at the Nurse's Station. The IDT note indicated Resident 2 continued having poor safety awareness. The IDT note indicated, "Comfort is goal and [with] regard to falls, minimizing serious injury is goal..." The IDT note indicated, "Will continue use of alarm, encourage wheelchair..." The IDT note did not specify providing supervision to Resident 2 to prevent further falls. The care plan for the actual fall on 9/10/16, was to continue plan of care. The fall risk care plan, initiated on 8/12/16, did not indicate new approaches and did not specify providing supervision to Resident 2 to prevent further falls. Fifth Fall: The Nurse's Note, dated 9/14/16, at 7:55 p.m., revealed Resident 2 had an unwitnessed fall and sustained a skin tear at his left elbow and injury in the back of Resident 2's head which required Resident 2 to be sent to an Emergency room for evaluation. The IDT Conference Record, dated 9/15/16, indicated on 9/14/16, at 7:55 p.m., Resident 2 was found on the floor next to the bed. The IDT note indicated an alarm was present but was not engaged. The IDT note indicated a fall prevention plan which included care alert posted in Resident 2's room. The IDT note did not specify how the facility would provide supervision to prevent Resident 2 from further falls. The Care Alert, dated 9/15/16, posted in Resident 2's room, indicated, "[Resident 2] is a high fall risk with a recent fall requiring a trip to the ER. Please make sure [Resident 2] has his loud alarm attached at all times! Check frequently as he is able to inadvertently remove the alarm..." The Care Alert did not specify how frequently to check the alarm or Resident 2. During an interview on 11/3/16, at 2:35 p.m., regarding, "Check frequently" for the alarm indicated in the Care Alert, the DON (Director of Nursing) stated she expected the staff check the alarm when staff made rounds every two hours; the Hall Monitor (an employee) walked back and forth in the hall, and when walking to Resident 2's room, the Hall Monitor could look inside the room from the hallway to see if the alarm was intact.

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When asked if the Hall Monitors were trained on how to prevent falls, the DON stated the Hall Monitors were trained to look if alarms were intact or pads were on the floor and to report to the nursing staff if anything was out of the ordinary. The DON stated a Hall Monitor was a facility staff member, but was not a caregiver. The DON stated the Hall Monitors did not do hands-on resident care; they could guide the resident and gently hold the resident's hands/elbows.

The IDT Conference Record, dated 9/16/16, for safety review related to the fall on 9/14/16, indicated to evaluate Resident 2's room to, "reconfigured room to have bed at a slight angle decreasing the likelihood of striking head during a fall. Mats at both side of bed." The IDT note did not specify providing supervision to Resident 2 to prevent further falls.

The fall risk care plan, initiated on 8/12/16, did not indicate new approaches and did not specify providing supervision to Resident 2 to prevent further falls.

During a concurrent observation and interview on 10/25/16, at 10 a.m., Resident 2 was in bed and awake. One floor mat was placed on Resident 2's right side, and one mat was up leaning against the wall below the window. When asked about his fall on 9/14/16, Resident 2 stated he did not remember the fall.

During an interview on 10/25/16, at 3 p.m., regarding Resident 2's fall on 9/14/16 at 7:55 p.m., Licensed Staff C stated a Hall Monitor found Resident 2 on the floor. Licensed Staff C stated when she arrived at the scene, Resident 2 was laying on the floor mat with the head against the wall on the left side of the bed. Licensed Staff C stated she did not hear the alarm. She stated Resident 2 took the alarm off all the time. When asked about fall prevention, Licensed Staff C stated when Resident 2 was not in bed, Resident 2 sat at the Nurse's Station. When Resident 2 was in bed, staff would listen to the alarm or Resident 2 yelling. Licensed Staff C stated they did not have a set time to check on Resident 2 because Resident 2 was not on an every 15 minute check.

During a concurrent observation and interview on 10/25/16, at 3:05 p.m., in Resident 2's room, one floor mat was on the right side of the bed, and one mat was up against the wall. Licensed Staff C stated the floor mat should be on the left side because Resident 2 got out of the bed from his left side.

During a concurrent interview and record review of Resident 2's care plans for fall and fall risk on 10/25/16, at 3:13 p.m., Licensed Staff C stated a care plan described what

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was the best care provided to the resident and communication with the care team. Licensed Staff C stated all nurses should review the care plans. When asked if the care plans specify providing supervision to Resident 2, Licensed Staff C reviewed the care plans, initiated on 8/12/16 and 8/15/16, and stated the supervision was to observe and monitor Resident 2 for 72 hours. When asked what happened after 72 hours, Licensed Staff C stated, "none" and the care plans did not specify supervision.

During an interview on 10/25/16, at 4:40 p.m., Unlicensed Staff O stated when Resident 2 was in bed, she would check Resident 2 approximately every five minutes. When asked how she knew about the five minutes, Unlicensed Staff O stated, "from the text book." When asked how she knew the care needed for a resident, Unlicensed Staff O stated she would ask other staff or look at the care plans, which would tell her about the resident. When reviewing Resident 2's care plan, which indicated Resident 2 had four falls from 8/12/16 to 9/10/16, Unlicensed Staff O stated she did not know Resident 2 had so many falls, "like constantly falling." Unlicensed Staff O stated by looking at the falls indicated in the care plan, Resident 2 should not be left alone. Unlicensed Staff O stated the care plan did not specify the frequency of checking Resident 2.

During a concurrent interview and record review on 10/26/16, at 2:50 p.m., the DON stated they tried different interventions including alarm, pad, and visual monitor for one shift only. The DON reviewed the fall and fall risk care plans, and stated the care plans did not specify providing supervision to Resident 2 to prevent falls.

During an interview on 10/26/16, at 3:55 p.m., Unlicensed Staff L stated he did not witness Resident 2's fall. Unlicensed Staff L stated he was not assigned to Resident 2, but he still helped check on Resident 2 and the alarm function at least every hour. Unlicensed Staff L stated when Resident 2 had repeated falls (4 - 5 times in a month), staff should be with Resident 2 all the time. Unlicensed Staff L stated they did not have enough CNAs (Certified Nursing Assistant) in the hall where Resident 2 resided. Unlicensed Staff L stated because of short staffing, they were not able to check residents as frequently as they would, to prevent residents from falling.

The Emergency Department Report, dated 9/14/16, indicated Resident 2 sustained a wound 2 cm in length in the head, and the wound was repaired with staples. The Emergency Department report indicated Resident 2 did not receive any imaging or extensive work-up because Resident 2 was on hospice with comfort measures only.

Resident 2 had three more falls after 9/14/16, as follows:

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a. The IDT note, dated 10/26/16, indicated Resident 2 fell from a wheelchair to the floor in the TV room;

b. The IDT note, dated 11/7/16, indicated Resident 2 fell on 11/5/16, witnessed by a Hall Monitor; and

c. The IDT note, dated 11/28/16, indicated Resident 2 fell on 11/26/16, sliding out of a wheelchair.

During an interview on 12/7/16, at 11:45 a.m., Unlicensed Staff BB stated there was no communication from the management to, "us" [Certified Nursing Assistants]. Unlicensed Staff BB stated they just put up signs in the utility room and in the resident's room and, "hoping us to know" what was going on. Unlicensed Staff BB stated when she looked at the sign with a picture of a bed without written instructions in Resident 2's room, she thought it was the instruction to put the head of the bed down with feet up and so she did. Unlicensed Staff BB stated after that they wrote, "keep bed low, keep bed at an angle."

During an interview on 12/9/16, at 7:20 a.m., the DON stated the plan was to put the bed in an angle to prevent injuries from falls. The DON stated she educated the staff about the sign but did not have a log to ensure all staff were educated and understood the sign.

1c. During a concurrent observation and interview on 10/25/16, at 8:30 a.m., in Resident 3's room, Resident 3 stated she fell approximately at 3 a.m. four days ago from her bed to the floor. Resident 3 stated she climbed back to bed because no staff were around to assist her. Resident 3 stated she told a nurse about the fall at approximately 5:30 a.m. the day she fell. She stated the nurse just told her to go back to bed.

Resident 3's MDS dated 8/9/16, indicated Resident 3's BIMS (Brief Interview for Mental Status) score was 13, which indicated Resident 3 was cognitively intact.

Resident 3's Fall Risk Evaluation, dated 8/4/16, indicated Resident 3 was at high risk for falls due to multiple problems including history of falls, ambulatory and elimination status, and gait/balance problem.

During an interview on 10/25/16, at 11:10 a.m., Licensed Staff B stated approximately seven hours after Resident 3 fell last Wednesday or Thursday, Licensed Staff B

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assessed Resident 3 by asking how Resident 3 was doing and also performed a head-to-toe assessment. Licensed Staff B stated he documented the assessment.

The Nurse's Note, dated 10/20/16 at 10:15 a.m., indicated, "[Resident 3] [up out of bed] in [wheelchair]. Denies any residual pain [secondary to fall]. [Resident 3] in wheelchair, going up and down hallway [without] difficulty. Will continue to monitor." The note did not indicate a head-to-toe assessment. There was no documentation of physician notification.

During a concurrent interview and record review on 10/26/16, at 8:10 a.m., Licensed Staff B stated there was no specific document for the head-to-toe assessment. Licensed Staff B stated he documented the head-to-toe assessment in the Nurse's Note. When asked about the Nurse's Note, Licensed Staff B stated the Nurse's Note, dated 10/20/16 at 10:15 a.m., was written by him. When asked for the fall protocol, Licensed Staff B stated they filled out the information forms which the night shift nurse should have done and turned it in to the DON.

During a concurrent interview and record review on 10/26/16, at 8:35 a.m., the DON reviewed Licensed Staff B's Nurse's Note, dated 10/20/16 at 10:15 a.m., and stated it was not well documented and did not show the head-to-toe assessment. The DON stated the post-fall protocol included completing the incident report, post-fall assessment, post-fall huddle, and neurological check flow sheet for unwitnessed fall. The DON stated staff had not notified her of Resident 3's fall. The DON stated staff did not complete the post-fall protocol procedures for Resident 3's fall on 10/20/16.

Review of the Fall Management Program Policy No. FA-01, documented following each fall, the licensed nurse would perform a post-fall assessment, the licensed nurse would notify the Director of Nursing and / or Administrator, and the Licensed Nurse would notify the resident's attending physician and responsible party of the fall incident.

1d. Resident 5's admission record indicated Resident 5 was admitted to the facility on 3/10/16, with diagnoses including difficulty in walking, muscle weakness, dementia with behavioral disturbance.

Resident 5's fall risk evaluation, dated 10/10/16, 11/24/16, and 12/6/16, indicated Resident 5 was at high risk for falls due to multiple problems including mental status (disoriented or intermittent confusion), history of falls, gait and balance problems, and medications. Resident 5 was on Risperdal (an antipsychotic medication which works by

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changing the effects of the chemicals to the brain. Common side effects includes dizziness, drowsiness, and tired feeling) 0.5 mg by mouth every day and Haldol (an antipsychotic medication which may work by blocking some chemical effects in the brain. Major common side effects include loss of balance control, muscle spasms, and shuffling walk) 70 mg intramuscularly every month for dementia with psychosis.

Resident 5's MDS, dated 3/17/16 and 9/16/16, indicated Resident 5's cognition was moderately to severely impaired.

First fall:

The Nurse's Note, dated 5/24/16 at 11 p.m. and the IDT note, dated 5/25/16, indicated Resident 5 had an unwitnessed fall on 5/24/16 at 7:45 p.m. in the bathroom. Resident 5 was found in the bathroom sitting on the floor wet with urine. Resident 5 complained of left shoulder pain and treated with Norco (pain medication). The IDT note indicated Resident 5 received antipsychotic (Haldol injection) prior to the fall. The IDT note indicated the Charge Nurse's plan to increase monitoring for a few hours after the monthly Haldol injection and recommended non-slip shoes for Resident 5.

Resident 5's care plan for fall risk prevention and management, initiated on 3/11/16, and re-evaluated on 6/16, 9/16, and 12/16, indicated interventions including, "Call light within reach, Remind resident to use call light - unable to use call light due to dementia, bed in low position..." The care plan indicated an intervention started on 11/7/16: Continue B-wing for increased supervision. The fall risk care plan did not reflect nor specify how to increase monitoring after the monthly Haldol injection.

Second fall:

The IDT note, dated 10/3/16, indicated Resident 5 had an unwitnessed fall in his room on 10/3/16 at 1:15 a.m. The IDT note indicated referring for physical and occupational therapy and continue to encourage wearing the hipster (Padded pants that cover the hip to cushion a fall to prevent injuries to the hip) when ambulating. The IDT note did not specify providing supervision to Resident 5.

Third fall:

The Nurse's Note, dated 10/9/16 at 2:30 a.m. and the IDT note, dated 10/10/16, indicated Resident 5 had an unwitnessed fall in his room on 10/9/16, with unknown time

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of fall. The IDT note indicated referring for physical and occupational therapy and continue to encourage wearing the hipster when ambulating. The IDT note did not specify providing supervision to Resident 5.

Fourth fall:

The IDT note, dated 11/24/16, indicated Resident 5 had a fall on 11/23/16 at 12 p.m. The IDT note indicated Resident 5 was walking in the hallway, "but still asleep." The Hall Monitor headed toward Resident 5, "but before she got to him he fell onto his [left] hip and elbow." The IDT note indicated, "will make a referral to PT/OT [Physical Therapy/Occupational Therapy]..." The IDT note did not specify providing supervision to Resident 5.

Fifth fall:

The Nurse's Note, dated 11/23/16, and the IDT note, dated 11/24/16, indicated Resident 5 had an unwitnessed fall in his room on 11/23/16 at 9:35 p.m. Resident 5 sustained a small skin tear on the top ridge of the nose. The IDT note indicated, "observe and monitor for 72 hours and on 15 [minutes check]."

Sixth Fall:

The Nurse's Note, dated 12/6/16 at 3 a.m., and the IDT note, dated 12/6/16, indicated Resident 5 was found on the floor in his room. The IDT note indicated every 15 minute checks was initiated after the first hour of neuro checks.

Resident 5's care plan for fall risk prevention and management, initiated on 3/11/16, re-evaluated on 6/16, 9/16, and 12/16, indicated interventions including, "Call light within reach, Remind resident to use call light - unable to use call light due to dementia, bed in low position..." The care plan indicated an intervention started on 11/7/16: Continue B-wing for increased supervision. The fall risk care plan did not reflect the 15 minute checks and who was/how to check Resident 5.

During a concurrent interview and record review on 12/8/16, at 8:35 a.m., regarding supervision for Resident 5, Unlicensed Staff CC stated she checked on Resident 5 whenever she saw him. Unlicensed Staff CC stated every staff in the hall was responsible to check on Resident 5. Unlicensed Staff CC stated she also reviewed care plans for resident care. When she reviewed Resident 5's fall risk care plan and asked

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her what did, "...increase supervision..." mean to her, Unlicensed Staff CC stated, "To me, may need one-to-one..." When asked her if Resident 5 was on one-to-one supervision, Unlicensed Staff CC stated she needed to check the documentation and found Resident 5 was on every 15 minute checks. Unlicensed Staff CC stated all staff were responsible for monitoring and documentation.

During a concurrent interview and record review on 12/8/16, at 8:55 a.m., Licensed Staff NN reviewed the fall risk care plan and stated, "...increase supervision..." meant every 15 minute checks. Licensed Staff NN stated the DON or ADON was responsible to review and update the care plans. Licensed Staff NN stated the care plan was used for following-up on residents and making goals for resident care.

During an interview on 12/9/16, at 7:20 a.m., Resident 5's fall risk care plan was reviewed with the DON. The DON stated the care plan did not specify supervision for Resident 5, and she understood that staff could have interpreted differently for, "...increase supervision."

1e. Resident 4's admission record and MDS, dated 10/3/16, documented Resident 4 was admitted 4/1/10. Resident 4's diagnoses included Chronic Obstructive Pulmonary Disease, Hypertension (high blood pressure), Cardiac Arrhythmia (problem with the rate or rhythm of the heartbeat), schizophrenia (a mental illness in which someone cannot think or behave normally and often experiences delusions), and muscle weakness (general).

Resident 4's MDS, dated 10/03/16, revealed the BIMS (Brief Interview for Mental Status) score was 3, which indicated Resident 4 was severely cognitively impaired. The MDS assessment indicated Resident 4 required supervision with one person physical assist with transfers and walking in his room. The MDS assessment indicated Resident 4 required one person physical assist for walking in the corridor and toilet use.

Resident 4's care plan for fall risk prevention and management, initiated on 10/04/16, indicated fall risk prevention and management approaches included, "Orient resident to environment each time changes are made, remove hazards from environment, maintain bed in low position and continue alarms in place on bed..." The care plan did not specify providing supervision to prevent Resident 4 from falling.

The short-term care plan (written care plan done for the actual fall), initiated on 10/14/16, indicated fall risk prevention and management approaches including, "hipsters"

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(padded type pants that cover the hips to cushion a fall), continue alarms, "replace when resident removes."

Short term care plan, re-evaluated on 10/18/16, indicated fall risk prevention and management approaches including video monitor of Resident 4's bed area, continue frequent observation, per discretion of nurse, every 15 minute mini-checks, and all other monitoring as needed.

During an interview on 11/09/16 at 9:15 a.m., Licensed Staff B was asked what every fifteen minute mini-checks and all other monitoring would mean to him. Licensed Staff B stated it would mean different things depending on what the issue was. When asked about falls, in relationship to every fifteen mini-checks and all other monitoring, he stated that would mean neuro checks for the licensed personnel, and for the CNA (Certified Nursing Assistant) it would mean vital signs. Regarding all other monitoring, he stated it would mean wanderguards, tag alarms, and alarms for bed and wheelchair.

During an interview on 11/9/2016 at 3:55 p.m., Unlicensed Staff R was asked about, "mini-checks" and what that meant to him. Unlicensed Staff R stated it would mean the nurse would do neuro checks, and he would do vital signs every 15 minutes times 2 hours, then every 30 minutes for 2 hours, then every hour for 4 hours. When asked about, "all other monitoring" he stated he would watch for pain, level of consciousness and safety. When asked regarding safety, he stated it could be done with alarms, like bed and chair alarms and a 1:1 (one staff to one resident), if possible.

During an interview on 11/9/16 at 4:05 p.m., Unlicensed Staff K was asked about, "mini-checks" and what that meant to her. Unlicensed Staff K stated it would mean vital signs (not sure how frequently) and checking them [the residents] to see how alert they were. When Unlicensed Staff K was asked what, "all other monitoring" meant to her, she stated alarms could be used, "sometimes a 1:1."

First Fall:

The Nurse's Note, dated 8/15/16, no time, indicated Resident 4 was found on the floor by his bed. Resident 4 had open abrasions to his knuckles that were cleaned and bandaged. He was placed in Geri-chair in front of the Nurse's Station on A-wing. A bed alarm, bed lowered, floor mat and alarm were placed on Resident 4.

The Interdisciplinary Team Conference Record, dated 8/16/16, regarding Resident 4's

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fall on 8/15/16 at 5:45 p.m., indicated Resident 4 had attempted a self-transfer and fell at the side of the bed. It indicated, "alarm" was on and hipsters were in place. The IDT Conference Record indicated to continue hipsters and alarms and care plans updated. There was no short-term care plan found.

Second Fall:

There was no documentation in the Nurse's Note for the fall of 8/21/16.

The IDT Conference Record, dated 8/22/16, indicated at 1:30 p.m., Resident 4 was up in a chair, and he attempted to reposition himself and slid down to the floor. Resident 4 slightly re-opened his right hand skin tears, and they were re-bandaged. The IDT Conference Record indicated to continue alarm and hipsters. The IDT Conference Record indicated care plans were updated.

There was no short-term care plan found.

Third Fall:

The Nurse's Note, dated 9/20/16, no time, indicated a, "Late Entry" for 9/17/16 at 9:55 a.m., Resident 4 was sitting in bed and leaned forward. The Nurse's Note indicated Resident 4 went to the floor. There were no visible injuries and no complaint of pain per the Nurse's Note.
The IDT Conference Record, dated 9/19/16, no time noted, indicated Resident 4's fall was not witnessed. The record indicated Resident 4 was sitting up in his chair and leaned forward and fell forward on his knees. The record indicated Resident 4 was at risk for falls related to his end stage Chronic Obstructive Pulmonary Disease (COPD - lung disease that makes it hard to breath), and he had poor safety awareness and often tried to transfer himself. The record indicated Resident 4 was to have a wheelchair and bed alarm in place. The IDT note did not specify providing supervision to Resident 4 to prevent further falls.

Resident 4's fall risk care plan, dated 10/4/16, indicated Resident 4 had an actual fall 9/20/16, and alarms were in place on the bed. No other changes were indicated.

Fourth Fall:

There was no documentation of a Nurse's Note found for the fall that occurred on

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10/13/16.

Physician's Progress Notes, dated 10/14/16, indicated Resident 4 had another fall. "Patient attempted to get up as he felt strong enough. He has poor balance. Medically stable, physically and mentally failing. Very high risk to fall."

Within the Nurse's Note, dated 10/17/16, at 2:30 p.m., written by the RT (Respiratory Therapist), it was indicated Resident 4 sustained a fall, which included bruising around the nose.

The IDT (Interdisciplinary Team) Conference Record, dated 10/14/16, indicated he [Resident 4],....."had been safe in bed with hipsters on and alarm in place per care team, when he unexpectedly got up, took his own alarm and hipsters off but had his boots on and ambulated to the closet area near a lift, falling to the floor..." The Physician had requested trial of mattress on the floor. Per PT (Physical Therapy) it was indicated the mattress on floor would increase risk, so would use a low bed, with mats at the bedside. The record indicated care plans were updated.

The fall risk care plan, dated 10/04/16, did not indicate any changes were made.

During an interview on 10/26/16 at 11:05 a.m., Licensed Staff F stated she found him [Resident 4] in his room but nearer the wall by the door, on his hands and knees trying to get up. Licensed Staff F did not witness the fall. She stated Resident 4 had a bloody nose. She called code STAT (immediately) for a fall and had help immediately. Licensed Staff F stated Resident 4 went to the Emergency Room. Licensed Staff F stated Resident 4 had a 1:1 [supervision] after he returned from the Emergency Room, but it did not occur too often due to staffing issues and stated there were not enough staff to cover for current residents and not able to find someone to come in to stay with residents.

Fifth Fall:

There was no documentation of Nurses Notes for the fall which occurred on 10/15/16.

During an interview on 10/26/16, at 12:01 p.m., Unlicensed Staff M stated she was aware (she stated she was in the shower room on 10/15/16, when resident fell) that Resident 4, "tripped over a hoyer lift (a mechanical lift) that someone forgot to take out." Unlicensed Staff M stated she came over (the hoyer lift was still in the room), but there

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were staff already helping him. She was aware Resident 4 went to the Emergency Room. Unlicensed Staff M stated with the 1:1 for the resident, it was much better. Unlicensed Staff M stated, "Especially on PM's there is not enough staff to watch everyone so a 1:1 for the resident really helps."

During an interview on 12/9/16 at 7:20 a.m., regarding Resident 4's fall on 10/15/16, with a hoyer lift in his room, the DON stated two CNAs were getting ready to assist Resident 4's roommate with a hoyer lift. The DON stated the two CNAs heard a code, "STAT" [immediately] from another room. The two CNAs left Resident 4's room to attend to the code, "STAT." The two CNAs left the hoyer lift in Resident 4's room. After the two CNAs left the room, Resident 4 might have gotten up from his bed and fell. Resident 4's face might have hit the base of the hoyer lift because the base of the hoyer lift had blood on it. The DON stated the two CNAs should have removed the hoyer lift from Resident 4's room prior to attending to the code, "STAT" and should not put one resident in danger in order to help another resident.

The IDT (Interdisciplinary Team) Conference Record, dated 10/17/16, indicated on 10/15/16, he [Resident 4] was found in a seated position in his room next to nightstand. "Resident is on 15 minute checks due to prior fall....Resident will be observed and monitored for 72 hours." The IDT Conference Record indicated to continue with hipsters and a mat at the bedside. The Conference Record indicated Resident 4 had a, "history of falls" related to forgetting to use his call light/waiting for assistance, taking off bed/chair alarms, and could not stand or ambulate without staff assistance.

The fall risk care plan, dated 10/04/16, did not indicate any changes were made.

Sixth Fall:

There was no documentation of Nurse's Notes for the fall that occurred on 10/17/16. The IDT (Interdisciplinary Team) Conference Record, dated 10/18/16, indicated on 10/17/16, Resident 4 had an unwitnessed, non-injury fall while attempting to get out of bed. Resident 4 had been at the Nurse's Station with a nurse before this fall and had requested to go back to bed.

The Nurse's Note, dated 10/24/16, indicated he [Resident 4] continued to attempt to ambulate and self transfer. "High fall risk.... Resident turning off alarm and picking it up and walking with it. Poor Safety awareness."

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The Care Alert, dated 8/22/16, and updated/reviewed on 10/17/16, and posted in Resident 4's room indicated, "[Resident 4] is at high risk of fall with injury due to his restlessness and frailty. Please make sure he is offered assistance with a urinal/toileting at least every 2 hours. Please make sure he has an alarm on at all times, keep a mat on the floor next to his bed; if he is out of bed, assist him to wear hipsters and appropriate non-slip foot wear. [Resident 4] may enjoy being up in a Geri-Chair for relaxation. If he does not choose to utilize a Geri-Chair, offer him his regular wheelchair. If he does use the Geri-Chair, please supervise him closely and assist him to safely get up when he wants to get up." The Care Alert did not specify a timeframe for, "supervise him closely."

During a concurrent observation and interview with Resident 4, on 10/25/16, at 10 a.m., Resident 4 was in the activity room, currently painting alone at a table. Resident 4 stated he enjoyed painting. Resident 4 stated he did not remember the fall. He hurt, "all the time." When asked about pain, he stated he had arthritis. He stated they gave him pain medication, and it helped. The Activity Assistant was helping two other residents at another table with art work. There were no other personnel in the activity room.

During an interview on 10/26/16, at 8:45 a.m., Licensed Staff E stated she did not use the care plan/update as it was difficult to use, and she was not sure how to use it. Licensed Staff E stated, "sometimes there's a 1:1 (person who cares for just one resident), but not often." Licensed Staff E stated the staff at the facility kept an eye on residents in the hallway. She stated, "This is how we manage."

During an interview with Licensed Staff B, on 10/26/16, at 10:15 a.m., when asked about Resident 4, he stated Resident 4 had days when he was, "hyperactive" (moving around, cannot keep still) and other days when he was, "hypoactive" (slept most of the day-only awake for meals). He stated the 1:1 made a difference, but due to staffing it did not always happen.

1f. Resident 6's admission record indicated Resident 6 was admitted to the facility on 3/25/16, with diagnoses including Alzheimer's disease (a brain disease causing a memory loss and disorientation), epilepsy (seizure) and depressive disorder.

The Admission Minimum Data Set, dated 4/1/16, and the most recent quarterly MDS, dated 9/29/16, indicated Resident 6 had a short-term and long-term memory loss and severely impaired cognition.

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	The CAA (CAA, a tool used to identify concerns and develop an individualized care plan), dated 4/1/16, indicated Resident 6 was a risk for falls, had Alzheimer's-type dementia, and was on Psychotropic drugs. During a record review on 12/7/16, a Nurse's Note, dated 11/25/16, indicated at 2:45 a.m., while ambulating on B Hallway, Resident 6 tripped on a pedal of another resident's wheelchair; thus causing a fall. Resident 6 had a laceration on the right side of her head. Resident 6 had a hipster on. The Nurse's Note also indicated, "prior to the fall, Resident 6, per report from the Night Shift nurse, was agitated, combative and in constant motion. Resident 6's behavior escalated to screaming, hitting staff and kicking other residents. PRN was given, but no avail." Staff was planning to notify her husband to help calm her prior to her fall. During observation, and interview on 12/7/16 at 8:45 a.m., Resident 6 was walking down the hallway back and forth multiple times, without being accompanied by anyone. When asked why Resident 6 was walking alone, Licensed Staff NN stated she did not know why the Hall Monitors were not walking with her. Licensed Staff NN also stated Resident 6 did not like Hall Monitors getting closer to her and if they did, Resident 6 started pushing and yelling at them and got agitated and combative, so they had to walk behind Resident 6. When asked how was that going to prevent Resident 6 from falling, Licensed Staff NN stated she did not know what to do. During record review on 12/7/16, a care plan, dated 11/25/16, documented an intervention for Resident 6 to have 1:1 supervision upon return from ED; During an interview on 12/9/16 at 8:20 a.m., Licensed Staff D stated she witnessed the fall on 11/25/16 at 8:45 a.m. Resident 6 was walking the hallway, tripped on the pedal of another resident's wheelchair and fell. Licensed Staff D stated she assessed Resident 6, and noted Resident 6 had a laceration to her right forehead. Licensed Staff D stated she called the treatment nurse who came, cleaned and put pressure on the wound. Licensed Staff D then called an ambulance that came and took Resident 6 to the hospital for evaluation and treatment. During record review on 12/7/16, IDT (interdisciplinary team) notes indicated Resident 6 had multiple falls from the date of admission (3/25/16) to date of the survey (12/5/16). Three of these falls caused injuries to Resident 6's head, which required Resident 6 to be sent to the acute care hospital for evaluation and treatments.

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	During a record review on 12/7/16, an IDT note, dated 8/2/16, indicated on 8/1/16, Resident 6 was ambulating all morning as Resident 6 usually was unable to sit still. Resident 6 was noted to be irritable and poking staff as they walked by. At one point Resident 6 grabbed the neck of one staff who was attempting to pick up Resident 6's Teddy Bear. Resident 6's Gait was shuffling as was usual, and she was leaning back as she stood. Suddenly, Resident 6 witnessed to be standing and fell backward bumping her right elbow and back of her head. Resident 6 had some bleeding in her head, pressure was applied and 911 was called for transport to the ED for evaluation and treatment. The physician was faxed regarding reducing meds. During a record review on 12/7/16, an IDT note, dated 10/26/16, indicated on 10/13/16, Resident 6 had a fall and sustained a laceration, to the left side of her head, requiring eight staples. The physician ordered increased Depakote (anti-seizure medication) for seizures, and Resident 6 continued to be at risk for falls. Resident 6's gait was steady, and Hall Monitors were available in B wing, according to IDT notes. 1g. Review of Resident 14's admitting History and Physical, indicated Resident 14 had severe dementia and was admitted to the facility on 7/6/16, after increasingly falling. The, "Fall Risk Assessment" dated 7/6/16, indicated Resident 14 was at high risk for falls due to multiple problems including disoriented, three or more falls in the past three months and poor vision. Resident 14's, "Fall Risk Assessment," dated 11/7/16, indicated he was at high risk for falls due to one to two falls in the past three months. Review of Resident 14's Post-Fall Assessments, Nursing Notes, and IDT Conference Record, indicated Resident 14 had a witnessed non-injury fall on 8/12/16 and 8/19/16 and an unwitnessed fall with injury on 11/5/16. IDT Conference Record, dated 11/5/16, indicated a Certified Nursing Assistant (CNA) found Resident 14 on the floor next to his bed on 11/4/16 at 9:15 p.m., laying on his left elbow and had a skin tear at left elbow. Resident 14's Nurse's Notes, dated 11/5/16, indicated: 1. CNA notified nurse Resident 14 was not able to bear weight on left leg and was complaining of pain, 2. Nursing assessment indicated Resident 14's left leg had a slight external rotation, and 3. Resident 14 was sent to the Emergency Department (ED) per Physician's Order. IDT Conference Record indicated the ED nurse contacted the facility's charge nurse who reported Resident 14 had a pelvic fracture. Review of, "Physician Orders," dated for the month of December, indicated starting on 11/5/16, Resident 14 was to be, "one-on-one with staff at all times."

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Review of, "Resident Care Plan Fall Risk Prevention and Management," revised and re-written on 11/8/16, indicated Resident 14: 1. Was at high risk for falls, 2. Had severe dementia, and 3. Had a significant change in condition whereby Resident 14 had a pelvic fracture, which occurred on 11/4/16; there was no indication for Resident 14 to be, "one-on-one with staff at all times."

Review of Resident 14's Care Plan Short-Term (start date 12/5/16), indicated an approach to the fall problem was for staff to notify the Charge Nurse immediately of any changes in behavior for reassessment of supervision needed;" there was no indication for Resident 14 to be "one on one with staff at all times."

The facility's policy and procedure titled, "Fall Management Program," revised 3/1/16 and 11/7/16, indicated, "The Facility will implement a Fall Management Program that supports providing an environment free from the hazards...The IDT will initiate, review, and update resident fall risks and Plan of Care at the following intervals: Admission, quarterly, annually, upon significant change of condition identification, and post fall as needed...Post-Fall Response A. Following each resident fall, the Licensed Nurse will perform a Post-Fall Assessment utilizing FA-01-Form A-Post Fall Assessment, and update, initiate or revise a Plan of Care. B. The Licensed Nurse will complete the FA-01-Form B-Neurological Flow Sheet for an un-witnessed fall, or witnessed fall with suspected or known head injury for seventy-two (72) hours following the fall incident. The Attending Physician will be informed if there is a deviation from the resident's normal status for further instruction...D. The Licensed Nurse will notify the resident's Attending Physician and responsible party of the fall incident...Post Fall Huddle A. Within 15-20 minutes after a fall the Licensed Nurse will initiate a post fall huddle utilizing the Post fall Huddle form...Fall Investigation/Reporting and Documentation A. Following a resident incident of fall, the Licensed Nurse who has the most knowledge about the incident, will complete AP-31-Form A-Incident and Accident Report Forms...E. The IDT will summarize conclusions after their review of the fall and circumstances surrounding the fall on an IDT note. The plan of care will also reviewed and the care plan will be revised as necessary in an effort to prevent further falls with major injury...Recurrent Falls...These residents may require more frequent observation of activities and whereabouts..."

During a concurrent interview and record review regarding QAA on 10/26/16, at 2:50 p.m., regarding resident falls, the DON (Director of Nursing) stated the QAA committee collected data including number of falls each month, but did not develop formal action plans to prevent falls. The DON stated direct care staff including CNAs (Certified

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Nursing Assistants) and nurses were not included in the QAA process and were not invited to the QAA meeting.

During a concurrent interview and record review on 12/8/16, at 3 p.m., regarding QAA, the Administrator stated the QAA developed an action plan for fall prevention and management, and the plan was started at the end of October, 2016. The Administrator provided and reviewed the action plan. The Administrator stated they tried to find the root cause of each fall but did not find the root cause of high incidence of falls or repeated falls in the facility as a whole. The Administrator stated some of the approaches of the action plan had not been implemented. When asked the reasons for the approaches not being implemented, the Administrator did not provide an answer. Regarding the effectiveness of the action plan when the facility had 17 falls on October 2016 and 20 falls on November 2016 (numbers of falls were based on incident logs), the Administrator stated they had not evaluated the action plan because the next QAA meeting had not occurred, but would be coming up soon. The action plan did not indicate a measurable goal with a target date.

2a. During a concurrent observation and interview on 10/25/16, at 8:05 a.m., Resident 17 was in bed and alert. Resident 17 stated sometimes she had to wait for a long time, up to approximately 30 minutes, for staff answering her call light and assisting her. Resident 17 stated this long waiting time happened anytime of the day. Resident 17 stated she felt really bad when she needed to go to the bathroom. When asked what would happen if she needed to go to the bathroom, Resident 17 stated, "just have to wait."

During a concurrent observation and interview on 12/5/16, at 3:05 p.m., Resident 17 was sitting in a wheelchair at her bedside. Resident 17 stated she usually had to wait for more than 30 minutes for staff answering her call light and assisting her. Resident 17 stated she felt bad when she had to urinate on herself and stayed wet for a long time. Resident 17 also stated she told the CNAs (Certified Nursing Assistants) every day that she [Resident 17] wanted to be out of the bed by 9:30 a.m. She stated the CNAs said they would help her as soon as they could, but they were always late until 10 a.m. or after 10 a.m. Resident 17 stated they did not have enough CNAs.

Resident 17's MDS (Minimum Data Set, a clinical assessment process providing a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 10/19/16, revealed Resident 17's BIMS (Brief Interview for Mental Status) score was 14, which indicated Resident 17 was cognitively intact.

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During an interview on 12/7/16, at 10:55 a.m., Unlicensed Staff AA stated she usually assisted Resident 17 up at 9:30 a.m. or 10 a.m. Unlicensed Staff AA stated she did not remember if Resident 17 told her about getting up by 9:30 a.m.

Resident 17's care plan for Activities of Daily Living (ADLs), initiated on 11/2/15, and re-evaluated on 11/16, indicated Resident 17 required assistance for ADLs including transfer, dressing, and personal hygiene.

2b. During a concurrent observation and interview on 12/5/16, at 2:17 p.m., Resident 18 was in bed and awake. Resident 18 stated sometimes he had to wait for 5 to 10 minutes for the staff to answer the call light. When asked how the 5 to 10 minutes wait time affected Resident 18, he stated, "depends what I needed." Resident 18 stated they did not have enough CNAs to help the residents.

Resident 17 and 18 were deemed by the facility to be interviewable.

The facility's policy and procedure titled, "Communication - Call System," revised 1/1/12, indicated, "...Nursing Staff will answer call bells promptly, in a courteous manner..."

During an interview on 12/9/16, at 7:20 a.m., regarding call light waiting time and the facility's policy and procedure of, "...answer call bells promptly...," the DON (Director of Nursing) stated staff should respond to call lights as quickly as possible with the goal of 3-5 minutes.

During an interview on 10/26/16, at 3:55 p.m., Unlicensed Staff L stated they did not have enough CNAs. Unlicensed Staff L stated the facility reduced the number of CNAs from three to two CNAs on B wing (a memory unit for residents who have memory problems). Unlicensed Staff L stated it was very stressful because Unlicensed Staff L could not do things for the residents as he wanted to do (i.e. brush their teeth, wash their hands, giving a bed bath, and other things) because of short staffing. Unlicensed Staff L stated they were not able to check residents as frequently as they would, to prevent residents from falling. Unlicensed Staff L stated two CNAs were not enough, and they needed three CNAs. Unlicensed Staff L stated the Hall Monitors (staff) could not provide any resident care; they just watched the residents and walked with the residents.

During an interview on 10/26/16, at 2:50 p.m., regarding staffing for fall prevention and

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	management, the DON stated they increased Hall Monitors to B wing. During an interview on 11/10/16, at 10:40 a.m., the Administrator stated B wing was the memory unit (residents had memory problems). The Administrator stated originally they had a total of three Hall Monitors covering from 6 a.m. to 8:30 p.m., but not at one time. The Administrator stated the first Hall Monitor worked from 6 a.m. to 2:30 p.m.; the second Hall Monitor worked from 9 a.m. to 5:30 p.m.; and the third Hall Monitor worked from 12 p.m. to 8:30 p.m. The Administrator stated about a week ago they increased the Hall Monitor to a total of four to cover 24 hours. She stated now the third Hall Monitor worked from 2:15 p.m. to 10:45 p.m., and the fourth Hall Monitor worked from 10:45 p.m. to 7:15 a.m. the next day. During an interview on 12/6/16, at 5:20 p.m., in B wing. Unlicensed Staff K stated she usually worked in C Wing where residents were more stable. Unlicensed Staff K stated she worked PM (afternoon/evening) shift from 2:45 p.m. to 11:15 p.m., and cared for 10 to 12 patients each work shift. Unlicensed Staff K stated she felt they had enough staffing, and she could stay with and help the residents as long as she needed. When asked what tasks included in one work shift for 10 to 12 residents, Unlicensed Staff K itemized the routine tasks with time required as following: (the numbers in parentheses at the end of each task were used for calculation of the minimum minutes required for one work shift) 1. Changing briefs (cloth protectors): 30 min (minutes) per resident for 3-4 residents every 1.5-2 hours equals to 90 - 120 min (90) 2. Water round: 15 - 20 min (15) 3. Dinner set up: 5 min per resident for 4 - 5 residents equaled to 20 - 25 min (20) 4. Feeding resident: 15 min for set up and 30 min for feeding for one resident equaled to 45 min (45) 5. Changing and emptying urinals: 10 min per resident for 2 - 3 residents equaled to 20 - 30 min (20) 6. Emptying urinary catheter bags: 10 min per resident for 2 residents equaled to 20 min (20) 7. Routine changing/making beds: 5 min per resident for 2 - 3 residents equaled to 10 - 15 min (10) 8. Changing wet beds: 5 min per resident for 2 residents equaled to 10 min (10) 9. Taking vital signs (blood pressure, temperature, etc.): 5 min per resident for 3 - 4 residents equals to 15 - 20 min (15) 10. Recording intake and output: 5 min (5)

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	11. Documentation of activities of living flow sheet: 20 min (20) 12. Shift change report: 15 min each for 2 reports equals to 30 min (30) 13. Breaks: 10 min each for 2 breaks equals to 20 min (20) 14. Meal break: 30 min (30) 15. Shower for residents: 20 - 30 min per resident for 2 - 3 residents equaled to 40-90 min (40) 16. Cleaning resident after meals: 20 min for total of 4 residents (20) 17. Assisted resident to bed: 10 min per resident for 4 - 5 residents equaled to 40-50 min (40) 18. Oral care: 5 - 10 min per resident for 2 residents equals to 10 - 20 min (10) 19. Toileting: 5 - 10 min per resident for 6 residents equals to 30 - 60 min (30) 20. Nail care: 10 min per resident for 3 resident equals to 30 min (30) 21. Peri care: 5 min per resident for 4 residents 4 times per shift equals to 80 min (80) 22. Grooming/shaving: 10 min for 4 residents equals to 40 min (40) 23. Dressing: 10 min per resident for 6 residents equals to 60 min (60) 24. Snack: 10 min (10) 25. Hand washing: before and after resident care: uncalculated 26. Answering call light: uncalculated The calculation revealed: One CNA had a total of 510 minutes per shift from 2:45 p.m. to 11:15 p.m., including breaks. A minimum of 710 minutes were required to complete the routine tasks in one work shift including breaks. This 710 minutes did not include the time for hand washing, answering call lights, reporting change of condition, and other unexpected circumstances. There were 200 minutes short for the staff to complete the routine tasks. During an interview on 12/7/16, at 9:44 a.m., Unlicensed Staff PP, who worked in A Wing (one of the resident care unit), stated she worked both AM (morning) and PM shifts. Unlicensed Staff PP stated they usually had three CNAs on morning shift, and each CNA had eight residents; they had two CNAs PM shift, and each CNA had 13 residents. Unlicensed Staff PP stated they needed three CNAs for PM shift. Unlicensed Staff PP stated they had not been had enough CNAs since she returned to work in June 2016. Unlicensed Staff PP stated they needed adequate staffing to feed residents properly and ensure safety and prevent falls. When asked about the tasks and time required for caring for the residents for one work shift, Unlicensed Staff PP provided the time for the routine tasks. The calculation of the time required for completion of the routine tasks revealed a minimum of 754 minutes for AM shift and 1052 minutes for PM shift, including all tasks and breaks. The CNAs shifts (AM, PM, & Nights) consisted of a

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	total of 510 minutes, which included the breaks. There were a minimum of 244 minutes short for AM shift and 542 minutes short for PM shift. This calculation did not include time for hand washing, answering call lights, reporting change of condition, other unexpected situations, and toileting, as she stated toileting required 6 - 10 minutes per one resident, and she assisted different residents throughout eight hours. During an interview on 12/7/16, at 11:45 a.m., Unlicensed Staff BB, who worked in B wing, stated they, "never" staffed sufficiently. Unlicensed Staff BB stated they had two CNAs, and she had 12 residents. Unlicensed Staff BB stated they needed at least three CNAs. During an interview on 12/7/16, at 4:45 p.m., Staffing Coordinator DD stated she did the schedules for all CNAs and RNAs (Restorative Nursing Assistants). Staffing Coordinator DD stated she scheduled staff according to the resident census and number of falls. Staffing Coordinator DD stated for full census, she usually scheduled three CNAs for AM and PM shifts in one unit (The facility had three units: A wing, B wing, C wing), and each CNA had 12 residents; two CNAs for night shift each unit, and each CNA had 22 residents. Staffing Coordinator DD stated if there were a lot of falls (on 12/8/16 at 10:35 a.m., she stated, to her one fall was a lot) in a unit, she would schedule more CNAs or Hall Monitors to that unit. Staffing Coordinator DD stated if there were a lot of falls (on 12/8/16 at 10:35 a.m., she stated, to her one fall was a lot) in a unit, she would schedule more CNAs or Hall Monitors to that unit. Staffing Coordinator DD stated Hall Monitors walked back and forth in the hallway. If the Hall Monitor saw a resident getting out of bed, the Hall Monitor reported to the CNA or the nurse. The Hall Monitors were not certified for resident care. Staffing Coordinator DD stated the Hall Monitor might not be able to prevent the fall, because when the CNA or nurse arrived to the resident's room, the resident might have already fallen. Staffing Coordinator DD stated the staffing one CNA to 12 to 22 residents was, "doable" because the resident census and care fluctuated. She stated she was also a CNA. When asked about the routine tasks required for one CNA in one work shift, Staffing Coordinator DD provided time required for each routine task. She stated AM and PM shifts were about the same. The calculation of the time revealed a minimum of 850 minutes for one CNA to complete the routine tasks in a given AM or PM shift; each CNA had a total of 510 minutes per shift, which was 340 minutes short. Staffing Coordinator DD did not provide details of all tasks for night shift but stated the tasks for night shift were more on repositioning, toileting, catheter care, and peri care (cleaning the urinary, vaginal, and rectal areas).

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

Upon request for the days and shifts when Staff Coordinator DD scheduled more CNAs than a routine schedule because of, "a lot of falls," twice on 12/8/16 at 10:35 am., and 6:40 p.m., Staff Coordinator DD did not provide the days and shifts.

During an interview on 12/8/16, at 9:40 a.m., Unlicensed Staff QQ, who worked in Wing A (one of the resident care units), stated she worked AM (morning) shift. Unlicensed Staff QQ stated they usually had two CNAs on morning shift, and each CNA had 14 residents, and she had 14 residents this day. Unlicensed Staff QQ stated they needed more staff for each shift to provide good care for the residents. Unlicensed Staff QQ also stated they needed adequate staffing to feed, shower, and bathe residents properly and ensure safety and prevent falls. When asked about the tasks and time required for caring the residents for one work shift, Unlicensed Staff QQ stated it was a lot of work and it was very hard to complete all the work adequately. When asked how long each of the routine daily tasks she performed took her to complete, she stated the following:

1. Shower per resident: 25/30 minutes times (2/3) residents equaled to 50-90 (50).
. Bathing bed bath per resident: 25/30 minutes X (2/3) residents equaled to 50-90 (50).
3. Oral care: 10minutes X (14) residents equaled to (140) minutes.
4. Making a bed when resident is out: 10 minutes X (10) residents (100) minutes.
5. Making a bed when resident is in bed: 20 minutes X (2) residents equaled to (40) minutes.
6. Meal tray setup/document %: 10 minutes X (4/5) resident equaled to 40-50 (40) minutes.
7. Hand feeding: 40 minutes X (2/3) residents equaled to 80-120 (80) minutes.
8. Toileting residents: 10 minutes X (5/6) residents equaled to 50-60 (50) minutes.
9. Nail care: 15 minutes x (3/4) residents equaled to 45-60 (45) minutes.
10. Peri-care: 15 minutes X (4/5/) residents equaled to 80-100 (60) minutes.
11. Grooming/shaving: 15 minutes X (3/4) residents equaled to 45-60 (45) minutes.
12. Dressing residents: 20/30 minutes X (4) residents equaled 80-120 (80) minutes.
13. Catheters (empty/measure): 10 minutes X (3) residents equaled to (30) minutes.
14. Vital signs: 10 minutes X (14) residents equaled to (140) Minutes.
15. Charting each resident at the end of the shift: 5 minutes X (14) residents equaled to (70) minutes.
16. Serving supplements: 3 minutes X (10) residents equaled (30) minutes.
17. Massage to bony prominence: 10 minutes X (4/5) residents equaled to 40-50 (40) minutes.
18. Reposition each resident: 10 minutes X (7) residents equaled to (70) minutes.
19. Handwashing prior to each resident: 2 minutes X (14) residents equaled to (28) minutes.
20. Reporting change in condition: 10 minutes X (3) residents equaled to (30) minutes.

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	21. Answering call lights: 5 minutes X (14) residents equaled to (70) minutes. 22. Changing wet beds: 10 minutes X (3) residents equaled to (30) minutes. 23. Breaks: 10 minutes X 2 equaled to (20) minutes. 24. Meal break: 30 minutes X (1) equaled (30) minutes. 25. Assisting residents in bed: 5 minutes X (5) residents equaled to (25) minutes. 26. Recording intake and output: 10 minutes (10) minutes. 27. Recording of activities of daily living: 20 minutes (20) minutes. 28. Water rounds not included. The calculation indicated a minimum of 1593 minutes were required for one CNA to complete all the tasks, including breaks, for an AM shift. The 510 minutes allotted for the morning Shift starting from 7:15 a.m. to 2:45 p.m. was not enough; it required more than 3 times of that (1593) minutes to provide an adequate care for the residents. During an interview on 12/8/16, at 2:20 p.m., Unlicensed Staff RR stated she worked on C Wing for a long time, mostly on AM shift. Unlicensed Staff RR stated working on C Wing was a lot of work, but she got used to it. Unlicensed Staff RR had 13 Residents this day. During an interview on 12/8/16, 2:45 p.m., Unlicensed Staff SS stated she worked morning shifts on B wing for a long time, and she always had 12 residents except this week. Unlicensed Staff SS stated this week she had eight residents because the State was there. Unlicensed Staff SS stated they needed to have more staffing on the B Wing because there were a lot of confused residents who required more help and care. Unlicensed Staff SS added even though there were Hall Monitors on the floor, they could not do a lot of things the CNAs could do such as caring, cleaning, bathing, assisting residents to bed, and making beds. During an interview on 12/7/16, at 8:15 a.m., Resident 6's family member, who was there every day, stated he was not complaining, but he thought the facility needed more staffing for the B wing because of the large number of confused residents in the wing. During an interview on 12/7/16 at 5:50 p.m., when Unlicensed Staff MM was asked how long it took her to do her CNA duties on the PM Shift for the 13 residents she was assigned to on C wing, Unlicensed Staff MM stated:

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	1. Shower depended on if the resident was a total lift or just needed supervisions: Total lift: 25-30 min, Bed bath: 20-30 min, wheelchair/stand: 15-20 min, or supervised: 20 min. Unlicensed Staff MM had two residents whose baths were scheduled: 40 2. Oral care: 5-15 min depending if residents were mobile, had dentures, or bedridden: 2 bedridden (30 min) plus if 11 residents were mobile (55 min): 85 min 3. Meal tray set-up: 20 min 4. Feeder: 20-30 min. Unlicensed Staff MM had one feeder: 20 min 5. Toilet resident at least 3 times: 10 min. Unlicensed Staff MM had one resident that used the toilet: 30 min 6. 12 residents were incontinent: checked each resident 3 times per shift; if residents were dry it took 15 min and if half the residents are wet it took 40 min. 1 round all dry: 15 min and, 2 rounds whereby half the residents were wet: 40 x 2= 80 min for a total of 95 min 7. Dress for bed: 12 min per resident x 13 residents = 156 min 8. Empty a Foley catheter: 2 min (Unlicensed Staff MM had 1) 9. Vital Signs: on average 3/4 residents took 15-20 min: 15 min 10. Passing Snack/Supplements: 20 min 11. Changing residents' water cup for the entire hall took 30-40 min: 30 min 12. Charting on 13 residents took 30-40 min: 30 min 13. Unlicensed Staff MM breaks included a 30-minute meal break and two 10-minute breaks: 50 min The calculation revealed, if Unlicensed Staff MM was to perform all the above PM tasks on her own during a total of 510 minutes per shift from 2:45 p.m. to 11:15 p.m., including breaks for 13 residents, it would have taken her a minimum of 593 min. This did not account for hand washing in between each resident, reporting change of condition, repositioning residents every two hours (Unlicensed Staff MM had two bedridden residents), answering call lights, and other unexpected circumstances. The facility's policy and procedure titled, "Nursing Department - Staffing, Scheduling & Postings," revised 1/1/12, indicated, "The Facility will employ Nursing Staff that will be on duty in at least the number and with the qualifications required to provide the necessary nursing services for residents admitted for care."

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

During a concurrent interview and record review on 12/8/16, at 3 p.m., regarding QAA for staffing, the Administrator stated their target for staffing was to have six to seven CNAs (Certified Nursing Assistants) in the whole building for AM (morning) and PM (afternoon/ evening) shifts so each CNA took care of 9 - 11 residents in an eight-hour shift. When asked if a CNA had sufficient time to take care of 9 - 11 residents, the Administrator stated, "yes" because the activity staff, scheduler, and RNA (Restorative Nursing Assistant) were also CNAs and helped for dining. The Administrator further stated one CNA had more than 15 residents on night shift. The Administrator stated the QAA did not have an action plan for staffing, because the facility did not have staffing problems.

3. During an interview on 12/7/16, at 11:45 a.m., Unlicensed Staff BB stated there was no communication from the management to, "us" [Certified Nursing Assistants]. Unlicensed Staff BB stated they just put up signs in the utility room and in the resident's room and, "hoping us to know" what was going on. Unlicensed Staff BB stated when she looked at the sign with a picture of a bed without written instructions in Resident 2's room, she thought it was the instruction to put the head of the bed down with feet up and so she did. Unlicensed Staff BB stated after that they wrote, "keep bed low, keep bed at an angle."

During an interview on 12/9/16, at 7:20 a.m., the DON stated the plan was to put the bed in an angle to prevent resident injuries from falls. The DON stated she educated the staff about the sign, but did not have a log to ensure all staff were educated and understood the sign.

During an interview on 10/26/2016, at 8:45 a.m., Licensed Staff E stated she was unsure of what QA/PI (Quality Assurance/Performance Improvement) did and what the subject was currently. She stated there were meetings where they talked about the patients and falls.

During an interview on 10/26/2016, at 11:05 a.m., Licensed Staff F stated she knew that the DON (Director of Nursing) and the DSD (Director of Staff Development) were involved. She stated she was not sure what they were working on at this time. She stated as a travel nurse (a nurse who travels to work in a temporary nursing position), she did not know much about the PI (Performance Improvement) process at the facility.

During an interview on 10/26/2016, at 12:01 p.m., Unlicensed Staff M stated she did not know what that was.

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

The facility's policy and procedure titled, "Quality Assessment and Assurance Committee - Composition & Duties," date revised 1/1/12, indicated under Purpose, "To promote the quality of resident care by overseeing, identifying, tracking, addressing and follow-up on all quality issues." The policy and procedure did not specify how to communicate the QAA minutes to other staff who did not attend the QAA meetings.

Therefore, the facility's Quality Assessment and Assurance Committee (QAA) failed to:

1. Develop formal corrective action plans or implement the action plans to prevent falls, which caused harm to residents as evidenced by: The facility did not provide adequate supervision and assistance, revise fall risk care plans and implement the care plans, follow fall protocol for post-fall assessment and management to prevent falls and injuries, for Residents 1, 2, 3, 4, 5, 6, and 14 when:

a. Resident 1 walked to the restroom unassisted, grabbed the rod across the restroom entrance and fell on the floor on 8/28/16. This caused Resident 1 to sustain a left humeral neck (upper arm bone just under the shoulder joint) fracture which required admission to an acute care hospital for treatment.

b. Resident 2 had five falls during a one-month period from 8/12/16 to 9/14/16. Resident 2 sustained a head injury from the last fall on 9/14/16, which required Resident 2 to be sent to an acute care hospital for evaluation and treatment. After 9/14/16, Resident 2 had three more falls on 10/26/16, 11/5/16, and 11/26/16.

c. Staff did not follow their fall protocol for post-fall assessment and notify the physician of a fall, when Resident 3 reported having fallen on 10/20/16. This resulted in Resident 3 not being evaluated after the fall until 10/25/16 (five days later).

d. Resident 5 had six falls during a six and one-half month period from 5/24/16 to 12/6/16. On 5/24/16, Resident 5 fell and sat on the floor in the bathroom which was wet with urine. A fall on 11/23/16, resulted in Resident 5 sustaining a small skin tear on the top ridge of the nose on 11/23/16 at 9:35 p.m. (This was the second fall this day).

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	e. Resident 4 had three falls during a one-month period from 8/16/16 to 9/17/16. Resident 4 sustained a skin tear on the right hand from a fall on 8/16/16, and re-opened a skin tear on the right hand from a fall on 8/21/16. Resident 4 had three more falls during a one-week period from 10/13/16 to 10/17/16, which resulted in a nasal bone (nose) fracture from a fall on 10/13/16. f. Resident 6 had multiple falls in a six-month period from 5/22/16 to 11/25/16. Resident 6 sustained bleeding in the head from the fall on 8/1/16; a laceration (cut) on the left side of the head which required eight staples from the fall on 10/13/16. Resident 6 sustained a laceration on the right side of the head from the fall on 11/25/16. g. Licensed Staff did not revise Resident 14's (who had one unwitnessed fall on 11/4/16, which resulted in a skin tear to the left elbow and a fractured pelvis), "Fall Care Plan" to indicate Resident 14 was to be on, "one-on-one" with staff at all times starting 11/5/16, per Physician's Order. This failure to revise Resident 14's, "Fall Care Plan" had the potential for Resident 14 to fall again, causing injury or even death. 2. Identify staffing issues and ensure sufficient nursing staff to provide quality resident care, which caused harm to residents as evidenced by resident falls and injuries (refer to 1a - 1g), and residents' care needs were not being met when call lights were not answered in a timely manner for Resident 17 and 18, and Resident 17's need of getting out of the bed earlier in the morning was not honored. These failures resulted in Resident 17 staying wet with the urine and feeling bad, potentially compromising the residents' physical and psychosocial well-being. 3. Communicate QAA minutes to the staff. These failures also prevented the QAA committee from implementing and evaluating action plans to correct quality deficiencies and therefore was not able to determine effectiveness of changes to be implemented. The violation of the regulation had presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result.

State of California - Health and Human Services Agency | Department of Public Health

CIVIL MONEY PENALTY ASSESSMENT

Facility : Eureka Rehab & Wellness Center, LP

DATE	CITATION #	CLASS	PENALTY ASSESSED	TOTAL DUE
02/28/2017	11-2707-0012905-F	A	$20,000.00	$20,000.00
SECTION(S) VIOLATED				
F520				

This citation has been issued as a Class A.

Full Payment Due By : 04/29/2017

PAYMENT OPTIONS

Per Health and Safety Code, Section 1428.1, licensee may pay 65% of the amount shown above in the "Total Due" within 30 business days after issuance of this citation, or the minimum amount defined by law, whichever is greater in lieu of contesting the citation (Class A Citation penalty minimum amount defined by law is $2000). If licensee chooses not to exercise the 65% / 30 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
Fiscal Services and Revenue
Collections Unit
P.O. Box 997434, MS 3202
Sacramento, CA 95899-7434

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 A CITATION

A licensee may contest a class "A" citation or penalty assessment by directly filing an action in Superior Court. (Health and Safety Code Section 1428.)

To contest a class "A" citation or penalty assessment, a licensee must send written notification to the Department advising of its intent to adjudicate the validity of the citation in court. (Health and Safecty 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 "A" 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

2/28/17
Date