State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 11-2707-0012903-F

Date: 02/28/2017 Time: 9:38 a.m.

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

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $20,000.00	DEADLINE FOR COMPLIANCE 3/9/17 12:00 a.m.

F309

CLASS A **CITATION -- PATIENT CARE**

F309 §483.24, 483.25(k) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25
(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

The facility failed to: 1. adequately assess and treat Resident 3's pain and care plan to taper Norco (a medication for pain), which resulted in harm to Resident 3 who was crying in tears and was having difficulties with moving around due to severe pain in her left leg, secondary to a bone condition and a recent fall; and 2. follow through with a treatment order of Debrox (ear wax removal) for Resident 11, which caused Resident 11's left ear to be plugged up and loss of hearing.

Name of Evaluator:
Clara Wu
HFEN

Evaluator Signature : James Shannon HFEN

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

Signature : Dana A. Webb

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

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

1. Resident 3's admission record indicated Resident 3 was admitted to the facility on 8/2/16 with diagnoses including toxic encephalopathy (a nervous system disorder caused by exposure to toxic agents) and personal history of malignant neoplasm (a tumor), and paresthesia (a sensation of tingling, tickling, pricking, or burning) of skin.

Resident 3's MDS (minimum data set, a clinical assessment process provides a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems) dated 8/9/16 and 11/8/16, indicated Resident 3's BIMS (brief interview for mental status) score was 13 - 14, which indicated Resident 3 was cognitively intact.

During a concurrent observation and interview that started on 10/25/16, at 8:30 a.m., in Resident 3's room, Resident 3 was sitting in her wheelchair tilted to her right side. Resident 3 stated she had to sit tilted to her right side because she was having pain 9/10 (pain scale 0-10, 0 indicates no pain and 10 indicates most severe pain) in her left hip since early morning. Resident 3 stated that it was difficult for her to move around and it made her irritable due to the pain. Resident 3 stated she already asked for pain medication but, "they said I am a drug addict" and could not give me more medication. Resident 3 stated she fell from her bed to the floor at approximately 3 a.m. four days ago. Resident 3 stated she climbed back to bed because there were no staff around to assist her. Resident 3 stated she told a nurse about the fall and pain at approximately 5:30 a.m. the day she fell. She stated the nurse just told her to go back to bed. Resident 3 stated she had arthritis pain 4-5/10 in her left hip down to the leg, but the pain in the left hip increased to 8-9/10 after the fall. Resident 3 stated she thought she, "hurt something" from the fall. Resident 3 stated she told all of her nurses but nobody checked on her nor did they send her to the hospital. Resident 3 stated one of the nurses, Licensed Staff C, told her (Resident 3) she reported the fall because she wanted more pain medications. Resident 3 stated Licensed Staff C told Resident 3 that eventually all her medications would be taken away. Resident 3 stated she always had to wait for the pain medication for one to two hours after the scheduled time. Resident 3 stated that staff were mad at her and acted like she was, "a drug addict." When asked if she wished to have a staff member to check on her, Resident 3 started crying in tears and stated she was OK with the DON (director of nursing) or another one particular nurse but not the other nurses because they did not check on her and said she was a drug addict and that she was, "tired of it."

During an interview on 10/25/16, at 11:45 a.m., Licensed Staff C stated last night

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Resident 3 asked for Narcotics (opioid pain relievers). Licensed Staff C stated she explained to Resident 3 that her pain medication was not due and explained to her that her narcotic medication needed to be "tapered". Licensed Staff C stated Resident 3 mentioned about her left hip. Licensed Staff C stated she faxed a request for x-ray to the physician.

During an interview on 10/25/16, at 11:10 a.m., Licensed Staff B stated approximately 7 hours after Resident 3 fell last Wednesday or Thursday, Licensed Staff B assessed Resident 3 by asking how Resident 3 was doing and also performed a head to toe assessment and documented the assessment. Licensed Staff B stated no injuries noted related to the fall. Licensed Staff B stated Resident 3 usually complained of pain 8-9/10 in her left lower extremity. Licensed Staff B stated Resident 3 asked for Narcotic medications for pain "no matter what." Licensed Staff B stated Resident 3 had history of drug seeking behaviors and asked for narcotic medications even though she was sleeping in her wheelchair. Once she opened her eyes, she would ask for Narcotic medication. Resident 3 had PRN (as needed) Norco order and it was now changed to regularly scheduled Norco.

A 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. The nurse's note dated from 10/20/16 to 10/24/16, did not indicate a complete post fall assessment nor notified the physician of Resident 3's fall.

During a concurrent interview and record review on 10/26/16, at 8:10 a.m., Licensed Staff B stated no specific document was used for the head to toe assessment. Licensed Staff B stated he documented the head to toe assessment in the nurse's notes. When asked about the nurse's notes, Licensed Staff C stated the nurse's note dated 10/20/16 at 10:15 a.m. was written by him. When asked about the facility's fall protocol, Licensed Staff C stated staff would use a form which the night shift nurse should have done and should have turned 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 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 (staff meet together to discuss about the fall), and neurological check flow sheet

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for unwitnessed fall. The DON stated the staff did not complete the post fall protocol procedures for Resident 3's fall on 10/20/16.

During an interview on 11/8/16, at 9:10 a.m., the DON stated the facility's standard practice and her expectation was for the charge nurse to notify the physician on the same work shift the resident fell, either by fax or by calling the physician depending on the severity of injury.

The physician's order dated 10/14/16 indicated: Schedule Norco 5/325 (strength of the Norco) as one tablet by mouth 4 times a day for one week, then one tablet by mouth 3 times a day for one week, then one tablet by mouth 2 times a day for one week, then one tablet by mouth every morning for one week and off (discontinue).

The care plan for pain initiated on 8/4/16 with a goal date 11/16, did not indicate Resident 3 was to have Norco tapered and did not indicate approaches specific to taper the medication.

During a concurrent interview and record review on 10/26/16, at 8:10 a.m., when asked what care plan for tapering the Norco was for Resident 3, Licensed Staff B provided the MAR (medication administration record) with the Norco administration schedule. When asked again for care planning and what would he do when Resident 3 kept asking for Norco, Licensed Staff B stated he would re-direct Resident 3 by telling her that physician ordered for her narcotics to be tapered and she had to wait for the next scheduled dose. Licensed Staff B stated he had not reviewed the chart if the chart contained any care plan for tapering the Narcotics.

During an interview on 10/26/16, at 8:35 a.m., the DON stated she did not care plan the tapering Narcotics for Resident 3 and believed care plan was not in place. The DON reviewed Resident 3's chart and stated there was no care plan and she understood the need to care plan how the facility would help the resident in tapering the Norco besides telling her to wait. The DON stated Resident 3 had drug seeking behaviors, kept asking for Norco and staff had to tell her to wait.

During an interview on 11/1/16, at 9:20 a.m., the DON stated Resident 3's recent x-ray result after the fall on 10/20/16 indicated a condition that required a physician's referral for Resident 3 to have a hip replacement.

Resident 3's x-ray result dated 10/27/16, indicated Resident 3 had, "Severe avascular

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necrosis of the left hip without evidence of acute fracture." Avascular necrosis is a condition which commonly occurs in the hip when there is loss of blood to the bone and could cause the bone to die and collapse. The symptoms of avascular necrosis include severe pain that interferes with the ability to use the joint when the disease progresses and the bone and joint collapse.

During an interview on 11/3/16, at 2:35 p.m., when asked if the facility evaluated the underlying cause of the pain since Resident 3's admission until the x-ray on 10/27/16, the DON stated she was not aware of an evaluation of the underlying cause of the pain. The DON stated Resident 3 had been treated for chronic pain based on the admission diagnoses. The DON stated Resident 3 was not being sent out for imaging or work ups because Resident 3's insurance did not cover for rehabilitation.

During an interview on 11/8/16, at 10:05 a.m., when asked what was her expectation of being notified of a resident's fall, Physician S stated the facility staff usually notified her the same day or the day after the fall by fax or phone. Physician S stated the staff should have notified her earlier of Resident 3's fall. Physician S stated Resident 3's avascular necrosis was not a result from the fall, but avascular necrosis could cause increasing pain. Physician S stated Resident 3 had chronic hip pain and after the fall, she looked deeper and found Resident 3 had avascular necrosis of the hip. Physician S stated she referred Resident 3 for a hip replacement. Physician S stated she tried to taper Resident 3's Narcotics, but now she could not taper the Narcotics because of Resident 3's left hip avascular necrosis.

During a concurrent observation and interview that started on 12/6/16, at 8:16 a.m., Resident 3 was eating breakfast. Resident 3's face was grimacing. Resident 3 stated she was, "in a lot of pain" and needed medications. Resident 3 put on the call light. Unlicensed Staff AA responded to the call light and told Resident 3 that she would tell the nurse about the pain. Unlicensed Staff AA left the room and came back at 8:21 a.m. and told Resident 3 that the nurse [Licensed Staff B] stated he would give Resident 3 medications when the nurse arrived here [Resident 3's room]. Resident 3 stated Licensed Staff B would go room by room giving residents medications and asked what room Licensed Staff B was at this time. Unlicensed Staff AA stated the nurse was at room 2, which was about four rooms away.

During an interview on 12/6/16, at 12:40 p.m., regarding Resident 3's pain, Licensed Staff B stated Resident 3 had drug seeking behaviors and made up the pain. Licensed Staff B stated after x-ray of the left hip and found avascular necrosis, Resident 3 started

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complaining of left hip pain. Licensed Staff B stated he saw Resident 3 was in the wheelchair and self-propelled down the hallway this morning, but Resident 3 did not complain of pain. Licensed Staff B stated when he was giving medications including pain medication to Resident 3 at approximately 9 a.m., following his sequence, Resident 3 complained of pain 9/10 but Resident 3 closed her eyes resting. Licensed Staff B stated "If I have 9/10 pain, I will be screaming."

The nurse's note and the MAR (medication administration record) from 12/6/16 to 12/9/16 did not indicate a nursing assessment for Resident 3's complaint of pain on 12/6/16 at 8:16 a.m. to 8:21 a.m.

During an interview on 12/9/16, at 7:20 a.m., the DON stated the nurse should have assessed Resident 3 when the resident complained of pain. The DON stated the nurse should not wait for the sequence to give medication when the resident complained of pain because "you don't know" if it was a new onset of pain.

The facility's policy and procedure titled "Pain Management," date revised November 2015, indicated "A Licensed Nurse will assess residents for pain on admission, quarterly, when there is a new onset of pain, or significant change in condition. Facility Staff is responsible for helping the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain to the extent possible...The Licensed Nurse will develop a Care Plan for pain management, including non-pharmacological interventions...Nursing Staff will implement timely interventions to reduce the increase in severity of pain...Nursing Staff will also utilize non-pharmacological interventions by adjusting the resident's environment to reduce pain...The Licensed Nurse will update the Care Plan for pain management with any change in treatment and/or medication...Upon admission, quarterly, and with significant change in condition the IDT will meet to review the resident's Pain Assessment. The IDT will document the following...i. Summary of event causing pain; ii. Root cause analysis; iii. Referrals, as necessary, and iv. Interventions to prevent future pain..."

The facility's policy and procedure titled "Pain Management," revised November 2016, indicated "...Facility Staff will help the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain to the extent possible...Licensed Nurse will assess each resident for pain upon admission, quarterly, when there is a new onset of pain, exacerbation of pain..."

2. During an interview on 12/5/16 at 3:40 p.m. and 12/7/16 at 11:20 a.m., Resident 11

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	complained of her left ear feeling plugged. Resident 11 stated she had informed her nurse (could not recall nurse's name) about her left ear feeling plugged and has been waiting for some type of treatment. Resident 11 stated she was having difficulties hearing out of the left ear now due to it being plugged. During a concurrent interview and clinical record review on 12/7/16 at 11:25 a.m., Licensed Staff TT was asked if Resident 11 had received any ear treatment for her left ear. Licensed Staff TT checked to see if an order had been written regarding treatment for Resident 11's left ear. Licensed Staff TT stated an order was written for Debrox (earwax removal and treatment) to be started, but it did not look like it was ever started. Review of the "Physician Telephone Orders" written at 11/30/16 at 5:00 a.m. indicated Debrox 2 drops was to be inserted into left ear and then irrigate with warm water every evening for three days. Review of Resident 11's "Routine Medication Administration Record" (MAR) for November indicated the Debrox treatment was to be started 11/30/16 at bedtime and to be continued for the next two days, but there was no nurse's signature indicating it was ever started. Review of Resident 11's Routine MAR for December indicated Debrox treatment should have been given on 12/1/16 and 12/2/16, but there was no signature indicating the Debrox treatment was ever performed. Review of the facility's policy titled, "Physician Orders" revised 1/1/12, did not indicate how a licensed nurse would carry out the physician's order once the order was transcribed on to the resident's Routine MAR. Review of the facility's admission pack (given to all residents upon their admission), titled, "California Standard Admission Agreement for Skilled Nursing Facilities and Intermediate Care Facilities" dated 5/11, indicated all residents who are admitted to the facility have "a right to prompt medical care and treatment." The facility's policy and procedure titled "Resident Rights - Quality of Life," revised 1/1/12, indicated "Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect and individuality." Therefore, the facility failed to 1. adequately assess and treat Resident 3's pain and care plan to taper Norco (a medication for pain), which resulted in harm to Resident 3 who was crying in tears and was having difficulties with moving around due to severe pain in her left leg, secondary to a bone condition and a recent fall; and 2. follow through with a treatment order of Debrox (ear wax removal) for Resident 11, which caused Resident 11's left ear to be plugged up and loss of hearing.

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	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.

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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	11-2707-0012903-F	A	$20,000.00	$20,000.00
SECTION(S) VIOLATED				
F309				

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