State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 11-2707-0012998-F

Date: 02/28/2017 Time: 10:45 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

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

F323

CLASS A **CITATION -- PATIENT CARE**

F-323 §483.25(d)(1)(2) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

(d) Accidents.
The facility must ensure that -

(1) The resident environment remains as free from accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

The facility failed to maintain an accident hazard free environment, provide adequate supervision and assistance, and revise fall risk care plans for Resident 4 when: 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 reopened 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.

Resident 4's admission record and MDS, dated 10/3/16, documented Resident 4 was admitted on 4/1/10. Resident 4's diagnoses included Chronic Obstructive Pulmonary Disease, Hypertension (high blood pressure), Cardiac Arrhythmia (problem with the rate

Name of Evaluator:
Clara Wu
HFEN

James Shannon HFEN

Evaluator Signature :

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

Signature : Dana 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

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

A 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 11/9/16 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,

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	"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 supervision), 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 placed on resident were ordered. The Interdisciplinary Team Conference Record, dated 8/16/16, regarding Resident 4's 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 Resident 4's fall on 8/21/16. The IDT Conference Record, dated 8/22/16, indicated Resident 4, at 1:30 p.m., was up in a chair and he attempted to reposition himself and he slid down to the floor. Resident 4 slightly reopened 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

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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 (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 10/13/16.

A Physician's Progress Note, dated 10/14/16, indicated, "Pt. (patient) had another fall trying to get up soon [sic] feel strong enough. 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 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..." 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 low bed, mats at 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

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	[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 the resident went to the emergency room. Licensed Staff F stated Resident 4 had a 1:1 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 that 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 4 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 were staff already helping him. She was aware Resident 4 went to the Emergency Room. Unlicensed Staff M stated with the 1:1 for Resident 4, 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 Resident 4's 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. 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 10/17/216, indicated he [Resident 4] was found in a seated position in room next to nightstand on 10/15/16. "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

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bed/chair alarms and could not stand or ambulate with staff assistance.

The fall risk care plan, dated 10/04/16, did not indicate any changes, such as increased supervision, 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 of of bed. Resident 4 had been at the Nurses 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."

The Care Alert, dated 8/22/16, and updated/reviewed on 10/17/16, and posted in Resident 4's room noted, "[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 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 hurts, "all the time." When asked about pain, Resident 4 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 Activity Room.

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,

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	cannot keep still) and other days when he was, "hypoactive" (slept most of the day-only waking for meals). He stated the 1:1 made a difference, but due to staffing it did not always happen. Therefore, the facility failed to maintain an accident hazard free environment, provide adequate supervision and assistance, revise fall risk care plans for Resident 4 when: 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 reopened 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. 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	11-2707-0012998-F	A	$20,000.00	$20,000.00
SECTION(S) VIOLATED				
F323				

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