State of California - Health and Human Services Agency

SECTION 1424 NOTICE

CITATION NUMBER:

11-2707-0012991-F

Department of Public Health

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Date: 02/28/2017 Time:

107 Ams

Type of Visit:

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

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

Facility ID:

010000078

Capacity: 99

SECTIONS VIOLATED

CLASS AND NATURE OF VIOLATIONS

PENALTY ASSESSMENT

DEADLINE FOR COMPLIANCE

\$20,000.00

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 and provide adequate supervision and assistance for Resident 1 when: 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.

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

Name of Evaluator:

Clara Wu HFEN Vames SHANNON HEEN

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

Signature:

Name:

Title:

Administrator

Evaluator Signature

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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	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 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 Reside due to multiple problems including intermittent confusion, three months, and being legally blind.			
	re-evaluated on 7/16, indicated approaches for fall risk princluding, "Orient resident to environment each time char environment that supports minimized hazards over which	an for fall risk prevention and management, initiated on 1/22/16, and 5, indicated approaches for fall risk prevention and management sident to environment each time changes are made and provide an poorts minimized hazards over which the Facility has control" The ecify how the facility would provide supervision to prevent the		
t.	Resident 1's care plan for visual impairment, initiated on environment with items kept in consistent location, free fr handrails in hallway" The care plan for activities of daily indicated Resident 1 required assistance for toilet use.	om obstacles and clutteruses		
·	The Nurse's Note, dated 8/28/16, revealed Resident 1 has a.m., when Resident 1 was ambulating to the restroom a			
	The IDT (interdisciplinary team) Conference Record, date 8/28/16, at 9:10 a.m., Resident 1 walked to the bathroom doorway. Resident 1's hands grabbed the spring rod, whi	and stopped at the restroom		

the doorway for cleaning, and simultaneously leaned her weight backward expecting the rod to be stable like a hand rail. 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 was 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

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•	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, 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 leaned backward while talking to the 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 Housekeeping Staff P stated after she cle across the restroom doorway and went to did not tell Resident 1 that the rod was lef she did not tell any staff about the rod bec stated from the beginning of using this typ	eaned the restroom another hall. How ft in the doorway. cause they could	m, she left the rod with a sign usekeeping Staff P stated she Housekeeping Staff P stated see it. Housekeeping Staff P		

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

that the rod was terrible and not good for use because the rod did not have a spring and was easy to fall off. She stated the rod was not stable and when people grabbed the rod,

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the rod fell.

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	six to seven months, but they did not have a policy and procedure regarding the use of the rod.				
	Upon request for the manufacturer's guidelines for the rod, Housekeeping Supervisor Q provided a page documentation titled, "FACILITY MAINTENANCE," undated, indicated under, "A. Site Safety Hanging Sign," which did not indicate how to use the rod and sign safely.  Therefore, the facility failed to maintain an accident hazard free environment, provide adequate supervision and assistance for Resident 1 when:				
	entrance and fell on humeral neck (uppe	to the restroom unassi In the floor on 8/28/16. In arm bone just under Tute care hospital for tre	This caused Reside the shoulder joint) t	nt 1 to sustain a le	eft
	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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Department of Public Health

State of California - Health and Human Services Agency

## **CIVIL MONEY PENALTY ASSESSMENT**

Facility:

Eureka Rehab & Wellness Center, LP

DATE	GITATION#	CLASS	PENALTY ASSESSED	TOTAL DUE
02/28/2017	11-2707-0012991-F	A	\$20,000.00	\$20,000.00
		SECTION(S)	MOLATED	
F323				
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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

Date