State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 11-2707-0012999-F

Date: 02/28/2017 Time: 10:27 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, revise fall risk care plans and implement the care plan, follow fall protocol for post-fall assessment and management to prevent accidents for Residents 3, 5, and 14 when:

1. 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 after the fall).

2. 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

Name of Evaluator:
Clara Wu
HFEN

James Shannon HFEN

Evaluator Signature :

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

Signature :

Name : Dana A. Wells

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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with urine. A fall on 11/23/16 at 9:35 p.m., resulted in Resident 5 sustaining a small skin tear on the top ridge of the nose (This was the second fall on the same day, 11/23/16).

3. 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.

1. 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 staffs 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 fall 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 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,

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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 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.

2. 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 on the same day, 11/23/16).

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 changing the effects of the chemicals to the brain. Common side effects include 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

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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 was 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 had been 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 increase supervision. The fall risk care plan did not reflect nor specified 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 the his room at 1:15 a.m. The IDT note indicated referring for physical and occupational therapy and continued to encourage wearing the hipster (Padded pants that cover the hip to cushion a fall to prevent injuries of 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 of fall. The IDT note indicated referring for physical and occupational therapy and continued 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.

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	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 his 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 the room. The IDT note indicated every 15 minutes check 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, and had been 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 increase supervision. The fall risk care plan did not reflect the 15 minutes check and how/who to check Resident 5. During a concurrent interview and record review, on 12/8/16, at 8:35 a.m., regarding Resident 5's supervision, 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 her what did "...increase supervision..." mean to her, Unlicensed Staff CC stated, "To me, may need one-to-one..." When asked 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 minutes check. 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

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	NN reviewed the fall risk care plan and stated, "...increase supervision..." meant every 15 minutes check. 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." Therefore, the facility failed to maintain an accident hazard free environment, provide adequate supervision and assistance, revise fall risk care plans and implement the care plans, follow the fall protocol for post-fall assessment and management to prevent accidents for Resident 5, when: 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 his nose on 11/23/16 at 9:35 p.m. (This was the second fall on the same day, 11/23/16). 3. 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 disorientation and poor vision. Resident 14's, "Fall Risk Assessment" dated 11/7/16, indicated he was 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 8/19/16 and 8/12/16, and an unwitnessed fall, with injury, on 11/5/16. The 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 he had a skin tear at his 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 his left leg and was complaining of pain, 2. The 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

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	physician's order. The 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 December, indicated, starting on 11/5/16, Resident 14 was to be, "one on one with staff at all times." Review of, "Resident Care Plan Fall Risk Prevention and Management," revised and re-written on 11/8/16, indicate 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 the approach to fall problems 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," date 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 be 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

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activities and whereabouts..."

Therefore, the facility failed to maintain an accident hazard free environment, provide adequate supervision and assistance, revise fall risk care plans and implement the care plans, follow the fall protocol for post-fall assessment and management to prevent accidents for Residents 3, 5, and 14 when:

1. 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 after the fall).

2. 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 at 9:35 p.m., resulted in Resident 5 sustaining a small skin tear on the top ridge of the nose (This was the second fall on the same day, 11/23/16).

3. 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.

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