State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 11-2707-0012997-F

Date: 02/28/2017 Time: 10:55 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 for Resident 2 when: 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.

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.

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. Welch

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

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 fall 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 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 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.

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

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 Resident 2 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 the 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:

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 to continue 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.

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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 Resident 2's back of the 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 alarm was presented 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 that staff checked the alarm when staff made rounds every two hours; the Hall Monitor (an employee) walked back and forth in the hall and when the Hall Monitor walked to Resident 2's room, the Hall Monitor could look inside the room, from the hallway, to see if the alarm was intact. 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 staff, but was not a care giver. 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 an evaluation Resident 2's room to reconfigured room to have bed at

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	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 his 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, they sat Resident 2 at the nurse 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 in an every 15 minutes 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 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

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	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 times. Unlicensed Staff L stated they did not have enough CNA's (Certified Nursing Assistants) 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 could 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: 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.

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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 residents' 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 2 from 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.

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 for Resident 2 when:

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.

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	11-2707-0012997-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