CITATION NUMBER: 020011824

Date: 11/4/2015 12:00:00 AM

Type Of Visit: Complaint Investig.

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

Incident/Complaint No.(s) : CA00427921, CA00427921

Licensee Name: Alameda Healthcare & Wellness Center LLC

Address: 430 Willow Street Alameda, CA 94501

License Number: 020000268 Type of Ownership: Limited Liability Company

Facility Name: Alameda Healthcare & Wellness Center

Address: 430 Willow Street Alameda, CA 94501

Telephone :

Facility Type: Skilled Nursing Facility Capacity: 166

Facility ID: 020000043

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT	DEADLINE FOR COMPLIANCE
	CLASS: B CITATION: Patient Care	$2,000.00	11/18/2015

F 224

CLASS B **CITATION --** Patient Care

483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATIONThe facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.The facility violated the aforementioned regulation by failing to follow their policy that prohibits neglect by failing to call 911 when Resident 1 had a change of condition and deteriorated on 1/18/15. Resident 1 experienced increased shortness of breath and staff notified Resident 1's son who told staff his mother belonged in a hospital. The respiratory therapist placed Resident 1 on a mechanical ventilator without physician's orders and facility Staff did not call 911 for one hour after they were unable to assess her blood pressure. As a result, Resident 1 did not have the benefit of acute hospital services when her heart stopped and she was pronounced dead, six and one half hours after her initial symptoms of shortness of breath first appeared.Record review showed Resident 1 was a 65 year old woman who was admitted to the facility on 1/9/15 from the acute care hospital. According to the hospital record "Critical Care" progress note dated 1/4/15, Resident 1 had a past medical history of atrial fibrillation (condition of the heart where the two upper chambers contract very fast and with irregularity causing a problem with the rate and rhythm of the heartbeat and can cause blood clots). Prior to hospitalization, Resident 1 was on Coumadin to prevent blood clots from forming but had stopped taking the medication three weeks before her admission to the hospital. Resident 1 had developed a blood clot in her right arm requiring surgery to remove the clot on 12/21/14. On 12/22/14, Resident 1 had a stroke (blood clot in the brain)and she was transferred to another hospital for a decompressive craniotomy, which is a neurosurgical procedure in which part of the skull is removed to allow a swelling brain room to expand without being squeezed. The resident also had a tracheostomy (trach) surgically placed to create an opening through her neck into the windpipe to provide an airway and to remove secretions from her lungs. Review of the physician's admission orders to skilled nursing facility (SNF), dated 1/9/15, showed

Resident 1 was to receive oxygen at 5 liters per minute through her trach and the oxygen was to be adjusted to maintain an blood oxygen saturation (amount of oxygen in the blood) of greater than or equal to 92 percent. Resident 1 had an order for Duoneb nebulizer (aerosolized medication administered through the trach to open the air passages in the lungs) every four hours as needed for shortness of breath or wheezing (in the lungs) and Ambu bag (a hand-held self-inflating bag commonly used to provide positive pressure ventilation (push air into the lungs) of patients who are not breathing or not breathing adequately) at the bedside for emergency use. The physician orders for "Life-Sustaining Treatment" (POLST) dated 1/11/15, reflected the decisions made by the family as the legal decision makers, for, "Cardiopulmonary Resuscitation (CPR) and Full Treatment," which means staff were to provide manual heart compressions if Resident 1's heart stopped and prolong life by all medically effective means. In a telephone interview on 2/3/15 at 10:25 p.m., Resident 1's son stated that he received a phone call from RN 1, between 10 and 10:18 a.m., on 1/18/15, who told him his mother was having trouble breathing and had a fever. He asked RN 1 if she (Resident 1) had a stroke, and RN 1 told him, "No, but the doctor had ordered some tests." The son stated that he told RN 1 that his mother should be in a hospital, and RN 1 told him that they could take care of his mother there in the facility. He stated that an hour or two later he received a call from the doctor (MD) and he asked the MD why his mother was not in the hospital. When Resident 1's son arrived at the facility, he saw his mother was lying in the bed with one eye open, and one eye closed and the tubing was hooked up. He thought she was still alive, but she was dead. He stated that he was very upset that his mother was not sent to the hospital. During an interview on 1/18/15, RN 2 stated she was in charge of Resident 1 on 1/18/15 and during an interview on 2/4/15 at 1:30 p.m., RN 2 stated she did her first rounds at 6 a.m., on 1/18/15, and noted Resident 1 was having rapid breathing so she notified the respiratory therapist.RN 2 said Resident 1's breathing was labored by 10 a.m. she was sweating. RN 2 told RN 1 to call MD (the physician. RN 2's nurse's note written on 1/18/15 contained the following entries: At "6 a.m., Resident 1 had increased anxiety and mild shortness of breath. Her vital signs were, BP 157/85, (normal range 90-140 (systolic) over 60-90 (diastolic)), temperature 98.6 degrees Fahrenheit (without fever), pulse 100 beats per minute (normal rate 60 to 100 beats per minute), respirations 18 breaths per minute (normal 12 - 20 breaths per minute), blood oxygen saturation was 100 percent. At "7 a.m., Resident 1's trach was suctioned with a minimum amount of pale yellowish secretions and her oxygen saturation ranged from 97 to 100 percent." At "10 a.m., Resident 1 had labored breathing and the respiratory therapist (RT) was at the bedside. The nursing supervisor (RN 1) called the resident's physician, (MD) who said he was coming to the facility. RT placed the resident on a mechanical ventilator (a machine that generates a controlled flow of gas into the patient's airways) and administered the Duoneb nebulizer treatment via the tracheostomy. The oxygen saturation was 97-100 percent. The resident (1) was noted with diaphoresis (sweating) and her blood sugar at the finger was elevated at 315 milligrams per deciliter (mg/dl) (normal 60-100 mg/dl)."At "11:30 a.m., MD ordered a transfer to the acute hospital and the resident had, "Very weak palpable pulse on both wrist, by RN 1 and RT; despite all treatments administered and given and (she) even was placed on (mechanical ventilator), pt. (Resident 1) continues to have SOB (shortness of breath); RT started bagging (ambu bag) on portable tank with O2 (oxygen); RN 1 called 911...911 paramedics..here and take over." At "12:39 p.m., Pronounced dead by MD with 911 paramedics..."During an interview in the facility on 2/3/15 at 3 p.m., the RT stated that he started Resident 1 on mechanical ventilation and was with RN 2. He stated that RN 1 called MD and he wasn't sure which of the nurses, RN 1 or RN 2 said, "Put on mechanical ventilation per MD's orders; but he didn't see the written order. He agreed that he did not write progress notes in Resident 1's medical record, but provided a notebook containing a diary of notes regarding several residents titled "Weekly Notes" where he documented on Resident 1. According to RT's "Weekly Notes," on 1/18/15 there was an entry for Resident 1 at 9:15 a.m., that he gave a Duoneb treatment for shortness of breath, and "bagged" her, on and off, for 20 minutes. The entry further showed that Resident 1's heart rate was 109 beats per minute, and her respiration rate was 28 breaths per minute. The heart rate and respiration rates were both elevated above normal.In a telephone interview on 2/4/15 at 11:30 a.m., RN 1 stated that on that day (1/18/15) she called MD and he gave an order

for mechanical ventilation, but RN 1 stated that she did not write it down, MD was "on his way."RN 1 stated that between 10 and 11 a.m., the vital sign equipment was not registering a blood pressure and she could not find a large enough blood pressure cuff needed to take Resident 1's blood pressure manually. She stated that Resident 1 had a pulse, but it was not documented in the medical record. RN 1 stated that she did not think that she needed to call 911 because MD was coming to the facility and, "We were working on trying to get a blood pressure."In a telephone interview on 2/4/15 at 10:15 a.m., the MD stated that he received a call from RN 1 on 1/18/15, that Resident 1 was having difficulty breathing. He told her he was going to finish rounds and then come to the facility. He did not recall giving a telephone order for mechanical ventilation or what the settings would be, he stated, "RT knows the standard settings." He did not recall telling the nurse to keep Resident 1 in the facility until he arrived as opposed to calling 911, because that would be "inappropriate." He further stated that the, "Nurses are competent. They should know there is no demand that they must keep her (Resident 1) there (at the facility)." MD wrote a progress note on 1/18/15, timed from 11:30 a.m. - 1 p.m., that showed Resident 1 had a decreased level of consciousness with stable vital signs at 11:30 a.m., but had no response and had to be ventilated. (MD's) discussion with family led to a decision to transfer to the hospital and 911 was called, but Resident 1's heart stopped beating and aggressive cardiopulmonary resuscitation was started. Called family, (they were) upset. Likely diagnosis was extended cardiovascular accident (stroke) or cardiac arrest (heart attack) with a rapid deteriorating course. The Nurse Manager (RN 3) of the Subacute Unit where Resident 1 was receiving care, stated in an interview on 2/3/15 at 3:10 p.m., that there were no written orders from the physician (MD) for mechanical ventilation or for what the settings should be, and that RN 1 did not write any progress notes. RN 3 stated that she would have called 911 when it became apparent that the ventilator and breathing treatments didn't have an impact. She also said she would send a resident out to the hospital at the request of the family. A review of the facility's policy and procedure for, "Change of Condition Notification" dated 1/1/12, showed that, "...In emergency situations ...the Licensed Nurse will: Call the Attending Physician STAT;...If the resident deteriorates, the symptoms are serious ...call 911 for transport to hospital..."A review of the facility's undated policy and procedure titled "Reporting Abuse to Administrator", which the Administrator provided on 2/24/15 at 2:30 p.m., showed the, "Purpose (was) To protect residents from...neglect...by ensuring that all Facility personnel...report any incident or suspected incident of resident neglect...to the Administrator." Under the heading of "Definitions, "Neglect is described as, "...Failure to provide medical care for physical and mental health needs..."Therefore the facility failed to provide emergency care according to their policy by failing to call 911 to have Resident 1 transferred to the hospital when Resident 1 had a change of condition.The above violation has a direct relationship to the health, safety or security of patients.

Name Of Evaluator:
Cathy Fuglestad
HFEN

Evaluator
Signature:_____

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

Signature:_____

Name:_____

Title:_____

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE