CITATION NUMBER: 110012744

Date: 12/28/2016 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) : CA00501261, CA00501261, CA00501015

Licensee Name: Seaview Rehabilitation & Wellness Center, LP

Address: 6400 Purdue Drive Eureka, CA 95503

License Number: 010000066 Type of Ownership: Partnership

Facility Name: Seaview Rehabilitation & Wellness Center, LP

Address: 6400 Purdue Dr Eureka, CA 95503

Telephone :

Facility Type: Skilled Nursing Facility Capacity: 99

Facility ID: 010000060

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT	DEADLINE FOR COMPLIANCE
	CLASS: A CITATION: Patient Care	$20,000.00	1/8/2017 12:00:00 PM

F323

CLASS A **CITATION --** Patient Care

F323 §483.25(h)- Free of Accident Hazards/supervision/devices The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The facility failed to provide adequate supervision for one resident (Resident 1) and ensure her environment was free of accident hazards when she fell while one staff member, instead of the required two staff, attempted to transfer her using a Hoyer lift (patient lift that utilizes a sling to transfer residents). Resident 1 had a history of generalized weakness and significant muscle spasms and was dependent on staff for all of her care needs, including movement/transport. This failure caused Resident 1 to sustain multiple rib fractures, a hemothorax (blood accumulation in the space between the chest wall and the lung which can interfere with normal breathing; most common cause is chest trauma) and a skin tear. Resident 1's injuries caused her to have increased pain and to experience fear when she was subsequently moved with the Hoyer lift. Review of Resident 1's facility face sheet (medical information), dated 8/31/16, indicated Resident 1 was a fifty-seven year old female who was admitted into the facility on xxxxxxx. Resident 1's medical record indicated she had diagnoses including multiple sclerosis, generalized muscle weakness, and difficulty walking. Her physician progress note, electronically signed 9/7/16 at 6:54 a.m., revealed she had a history of significant muscle spasms. Review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 8/16/16 (ten days before her fall) revealed she was totally dependent on staff support for transferring and she required two staff for physical assistance with transferring. Review of her MDS dated 5/16/16 (three months before her fall from the lift) indicated Resident 1 was unsteady, had impaired balance during transfers, and had a recent fall at the facility. Review of Resident 1's MDS's dated 5/16/16 and 8/16/16 (prior to her fall) revealed she had no pain. Review of Resident 1's medical record document of monthly vital signs, weights, and pain assessment indicated Resident 1 had no pain from January, 2016 through August 3, 2016.

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Review of Resident 1's Medication Record Administration (MAR) indicated she had no pain from August 1 through August 26, 2016 but was given Norco (narcotic pain reliever) for generalized discomfort. Review of Resident 1's nursing care plan (direction for the nursing care an individual may need) dated 8/26/16 indicated Resident 1 fell to the floor while being transferred by staff and complained of pain to her right arm and right elbow. The care plan indicated Resident 1 would be sent to a local hospital emergency room for a post fall evaluation. Review of Resident 1's SBAR notes (facility document where nurses document the situation, background, appearance and review/notification of an incident), dated 8/26/16, revealed Resident 1 had fallen and had sustained a right arm skin tear and complained of increased pain in her right shoulder and elbow. The document indicated Resident 1's pain was 7 out of 10 (pain assessment score where 1 was no pain and 10 was worst pain imaginable) and she grimaced when her right arm and shoulder were touched. The document indicated Resident 1 was sent to the local hospital's emergency room for evaluation of possible right arm fracture. Review of the Emergency Department Report dated 8/26/16 at 9:24 p.m. (documented by Physician K) indicated Resident 1's chief complaint was "right elbow pain after fall." Review of the History & Physical Report, documented by Physician G (dated 8/27/16, no time) indicated the reason for Resident 1's hospital admission was "fall." Physician G documented that Resident 1 "was being transported" in some type of lift mechanism and she fell. Physician G indicated Resident 1 was "taken in for further evaluation." Review of hospital radiology (x-ray imaging) report dated 8/26/16 at 8:26 p.m. indicated Resident 1 had a chest x-ray from one view (XR Chest 1V). The report indicated Resident 1 was "status post fall" and had fractures of the right fifth through eighth ribs. Under subtitle "Impression," the report revealed Resident 1 had "multiple right rib fractures with associated minor right hemothorax..." The report was electronically signed by Physician H on 8/27/16 at 4:58 p.m. Review of Resident 1's hospital physician progress note dated 8/29/16 at 12:39 p.m. indicated Resident 1's imaging studies had been negative regarding her fall and fractures. The physician progress note was electronically signed by Physician J on 8/31/16 at 3:30 p.m. Review of Resident 1's medical record nurse's notes revealed she was transferred back to the facility via ambulance on 8/30/16. Review of an Interdisciplinary Team (IDT) conference record dated 8/31/16 indicated Resident 1 was status post fall and required pain management. An IDT conference record dated 9/1/16 indicated Resident 1 had fractures to her right fifth through eighth ribs, as noted on x-ray report from the hospital. The report indicated the facility notified Physician I of the x-ray results. During an observation on 8/31/16 at 2:05 p.m., Resident 1 was lying in her bed. During an interview at 2:10 p.m., Resident 1 had difficulty expressing herself verbally and nodded or shook her head in response to questions. When asked if she had fallen recently, Resident 1 nodded her head up and down, indicating yes. When asked where she fell, Resident 1 used her left hand to point to her right shoulder. After that movement, she made a facial grimace. When asked if she was in pain, Resident 1 nodded her head up and down, indicating yes. When asked if she had pain before she had fallen, she shook her head side to side, indicating no. When asked if she had pain after she fell, she nodded yes. At that time, she moved slightly and again grimaced. When asked if she wanted pain medicine from the nurse, she shook her head to indicate no. During an interview on 8/31/16 at 2:25 p.m., Licensed Nurse B stated Resident 1 was alert and oriented (aware of person, place and time; not disoriented) but had problems with speech. He stated she was able to tell you "yes" and "no" and was able to answer well that way. He stated he had medicated her for pain earlier that day. When asked how her pain compared to her pain before her fall, he stated normally she went to the dining room to eat her meals but she wanted to stay in bed that day, which was unusual for her. He stated she usually smiled more but she was not smiling that day. During an interview on 8/31/16 at 2:45 p.m., Certified Nursing Assistant C (CNA C) stated she had worked with Resident 1 approximately two weeks earlier. She stated Resident 1 required maximum assistance from staff but had gotten up for breakfast and lunch at that time. When asked if she had pain when she got her up two weeks ago, CNA C stated Resident 1 was, "perfectly fine" and had not had pain. CNA C stated she had fed Resident 1 that morning (8/31/16) in bed because she had not gotten up. She stated Resident 1 was in pain during breakfast and the elevated head of the bed had caused Resident 1 pain. During an interview on 8/31/16 at 3:00 p.m., CNA D stated he knew Resident 1 and

had taken care of her in the past. He stated it was hard to communicate with her but she could say "water" and "light" and was able to shake her head to indicate "yes" and "no." CNA D stated Resident 1 required maximum assistance from staff and they used a Hoyer lift to move her. He stated two staff moved her in the Hoyer lift. He stated Resident 1 got up in the wheel chair for all meals but she was now in pain and did not want to get up. During an interview on 8/31/16 at 3:20 p.m., Licensed Nurse E stated she was Resident 1's nurse the evening she fell from the Hoyer lift and she had gotten a stat (respond immediately) call to her room. She stated Resident 1 was lying on the floor, had a skin tear, and had complained of pain on her right side. She stated Resident 1 used her fingers to communicate that her pain was 7 out of 10 (on the pain scale). She stated CNA F was alone (no other staff were present) and he told her the Hoyer lift dropped Resident 1. She stated CNA F had gotten Resident 1 up in the Hoyer by himself. She stated CNA F was sent home after the incident (he did not finish working his shift). During an interview on 8/31/16 at 1:30 p.m., the Director of Nursing stated Resident 1 fell while CNA F was transferring her using a Hoyer lift. She stated Resident 1 had been injured and she had right shoulder pain and a skin tear. During an interview with Administrator A and the Director of Nursing (DON) on 8/31/16 at 3:45 p.m., Administrator A stated the root cause of Resident 1's fall was the CNA had not followed facility policy and procedure. She stated two staff members, not one, were required to transfer residents using a Hoyer lift. She stated facility maintenance staff had assessed the Hoyer's sling after the incident. She stated the sling was "okay" but it had not been hooked right. Review of Resident 1's nurse's note dated 8/31/16 at 2:50 p.m. (after she returned from the hospital) indicated Resident 1 was given Norco (narcotic pain reliever) for "moaning and groaning." Review of Resident 1's Medication Administration Record (MAR) indicated she received additional Norco later that day for "moaning/groaning." Review of Resident 1's night shift nurse's note dated 9/1/16 indicated she was given Oxycodone (narcotic pain reliever stronger that Norco) for, "severe pain, a lot of facial expressions..." and for hands clutching and tightening up. Review of Resident 1's nurse's note dated 9/3/16 at 10:25 a.m. indicated Resident 1 complained of right sided chest pain and staff gave her Norco for pain relief. The note further indicated Resident 1 was "very guarded while in Hoyer sling." A nurse's note dated 9/4/16 at 11:10 a.m. indicated Resident 1 complained of right arm/shoulder and right side chest pain and staff gave her Norco with good results. The note further indicated Resident 1 was "still afraid of using lift" to get in and out of bed. During a telephone interview and concurrent record review on 10/4/16 at 10:20 a.m., Physician I (Resident 1's primary physician) stated she was Resident 1's doctor. She stated Resident 1 was totally dependent on staff for her care and only one CNA was assisting her at the time she fell from the Hoyer lift. When asked if Resident 1's radiology results, dated 8/26/16, (that indicated Resident 1 had multiple right rib fractures with a right hemothorax) was caused from her fall from the Hoyer lift, Physician I responded, "yes." She stated that Physician J's progress note, dated 8/29/16 at 12:39 p.m., (that indicated Resident 1 had not sustained rib fractures) was not correct. Review of facility policy titled "Total Mechanical Lift" (revised 1/1/12) indicated a mechanical lift would be used appropriately to facilitate transfers of residents. The policy indicated "II. At least two people are present while resident is being transferred with the mechanical lift." Therefore, the facility failed to provide adequate supervision for Resident 1 and ensure her environment was free of accident hazards when she fell while one staff member, instead of two staff, attempted to transfer her using a Hoyer lift. Resident 1 had a history of generalized muscle weakness, muscle spasms, and was totally dependent of staff for all care needs and the facility failed to ensure she received care in a manner designed to meet her individual needs. These failures resulted in Resident 1's multiple rib fractures, hemothorax, and skin tear and caused her to experience increased pain and fear. The regulatory violation described presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result.

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

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Name Of Evaluator:
Eileen Brooker
HFEN

Evaluator
Signature:_____

Signature:_____

Name:_____

Title:_____

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