

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555323</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/09/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>AVIARA HEALTHCARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>944 REGAL ROAD, ENCINITAS, CA 92024 SAN DIEGO COUNTY</b>		
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	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit.</p> <p>Representing the Department of Public Health: [REDACTED], HFEN</p> <p>CLASS AA CITATION -- PHYSICAL ENVIRONMENT 08-1518-0006270-F Complaint(s): CA00187815, CA00187885 F323 42 C.F.R. 483.25 (h) Accidents. The facility must ensure that: (1) The resident environment remains as free of accident hazards as possible.</p> <p>Based on observation, interview and record review the facility failed to provide a safe, hazard free environment for one patient (A). As a result, Patient A suffered 2 falls. The first fall, which was unwitnessed, took place on 5/9/09 at 6:00 A.M., in his room. The second fall took place 21 hours later, on 5/10/09 at 3:00 A.M., when Patient A came out of his room, lost his balance, and grabbed for a mechanical lift which was stored outside of his room. Patient A fell pulling the mechanical lift down onto the floor, striking his head on the metal frame of the mechanical lift. This fall caused such a severe bleed in Patient A's brain, that the entire brain was pushed one third of an inch past the center point of his brain to the right side. Patient A died three days later. According to the coroner's report, Patient A died from blunt force trauma to the head, exacerbated by his renal disease.</p>			

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12:47:08PM

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	<p><b>Continued From page 1</b></p> <p>Findings:</p> <p>Patient A was admitted to the facility on 4/28/09 with diagnoses that included rehabilitation for a fractured left hip per the Resident Admission Record. Per the medication administration record, Patient A received aspirin and, Lovenox, medications that are used to prevent the formation of blood clots after surgery. These medications would increase a patient's risk for bleeding.</p> <p>On 5/12/09 at 12:45 P.M., and again on 5/13/09 at 8:30 A.M., Patient A's clinical record was reviewed. According to the patient's history and physical dated 4/29/09, authored by the patient's primary care physician, Patient A was alert and oriented on admission. According to the physical therapy and occupational therapy notes, Patient A had been doing well with these services from his admission on 4/28/09 through 5/9/09. The nurse's notes, described Patient A as alert and responsive and able to ambulate to the bathroom with a front wheeled walker.</p> <p>On 5/9/09 at 6:00 A.M., Patient A fell, according to interviews conducted with Patient B on 5/13/09 at 11:00 A.M., and again on 5/14/09 at 11:00 A.M. Patient B was the roommate of Patient A. Patient B was interviewed through a Spanish interpreter and stated that the curtain between the two beds was pulled so he could not see his room mate. Patient B stated that at about 6:00 A.M., he heard Patient A fall. Patient B stated that he used his call light to call for the nurses. Patient B stated that two nurses came into the room and lifted Patient A</p>				

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	<p><b>Continued From page 2</b></p> <p>back into the bed.</p> <p>An interview was conducted with Licensed Vocational Nurse 1 on 5/13/09 at 3:00 P.M. Licensed Vocational Nurse [LVN] 1 stated that a discussion with Patient A's son concerning the possible use of a tab alarm took place on 5/9/09, sometime after dinner. A Tab alarm is a patient safety device that when activated alerts staff when a patient attempts to exit their bed. LVN 1 showed Patient A's son how a Tab alarm would work and stated that the son agreed to the use of the Tab alarm.</p> <p>On 5/10/09 at 3:00 A.M., approximately 21 hours after Patient A's first fall, the patient fell a second time. A telephone interview was conducted with Registered Nurse 1, on 5/13/09 at 1:20 P.M. RN 1 denied having knowledge of Patient A's first fall dated 5/9/09, however had witnessed the patient's second fall on 5/10/09.</p> <p>On 5/17/09 at 5:40 A.M., RN 1 was interviewed concerning Patient A's second fall. RN 1 stated, "While I was charting at the nurse's station I heard a noise and looked up to see the Hoyer lift move, apparently the wheels of the lift were not locked." The Hoyer lift (a mechanical lift which is utilized to lift patients out of bed) was stored approximately 1 foot outside of Patient A's doorway. The portion of the corridor where the mechanical lift was stored outside of Patient A's room did not have a hand rail attached to the wall to assist patients in stabilization and ambulation. RN 1 stated that about 3:00 A.M., the patient was coming out of his room (501) wearing nothing but a T-shirt. Patient A lost his balance, and grabbed for the mechanical lift</p>				

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	<p><b>Continued From page 3</b></p> <p>[Hoyer]. Patient A fell pulling the mechanical lift over with him, striking the left side of his head on the bottom portion of the lift. The nurse stated that Patient A was assessed with elevated blood pressure, and decreased level of consciousness, first aid was administered to the patient's lacerations on the left side of his head, and the laceration to his left elbow. Patient A was transported to a nearby hospital for further evaluation and treatment.</p> <p>On 5/13/09 between 5:35 A.M. and 7:15 A.M., CNA's P, Q, R, S along with LNV's 2, 3 and 4 were interviewed and stated that the Hoyer lift was to be stored in the shower room when it was not in use. The Hoyer lift was observed outside of Patient A's room in the corridor during the hours of these interviews.</p> <p>On 5/13/09 at 2:45 P.M., LVN 1 stated that the Hoyer lift, was stored in the corridor by room 501, (Patient A's room) all the time. Stating that the lift was plugged into the emergency outlet to charge its battery.</p> <p>On 5/13/09 at 8:20 A.M., the Director of Nurses stated in an interview, that the expectations of staff were to store the mechanical lifts in the shower rooms when they were not in use. The Director of Nurses stated that there was no written policy concerning the storage of equipment.</p> <p>The emergency room History and Physical was reviewed on 5/12/09 at 9:00 A.M., which indicated that the Neurosurgeon was consulted. The Neurosurgeon evaluated Patient A and felt that</p>				

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	<p><b>Continued From page 4</b></p> <p>given the patient's mental status and the severity of his head bleed that recovery was very unlikely and that his prognosis was poor.</p> <p>The CT (computerized tomography) scan dated 5/10/09 at 4:51 A.M., of Patient A's brain, indicated that the bleeding that Patient A suffered was so severe on the left side where he struck his head, it caused a 2.5 centimeter (approximately 1 inch) bleed that stretched from the midsection of the front of the brain, extending around the left side, to the mid section of the back of the brain, basically involving the whole left half of the brain. The bleeding was so severe that it caused the entire brain to shift 8 mm (8 millimeters approximately 1/3 of an inch) to the right.</p> <p>Patient A received medications which increased his risk for bleeding. Patient A experienced an unwitnessed fall on 5/9/09, the facility placed a Tab alarm on Patient A and approximately 21 hours later, Patient A fell a second time. While facility staff had placed a tab alarm on the patient's gown, which should have sounded as the patient got up out of bed, Patient A exited his room wearing only a T-shirt. As the patient left the room, he lost his balance, grabbed onto the mechanical lift which was stored outside of Patient A's room (501) as that portion of the wall did not have hand railing to afford a patient the ability to stabilize themselves or ambulate. According to 7 separate staff interviews, the mechanical lift was supposed to be stored in the shower rooms when not in use. Observations conducted on 5/13/09, and again on 5/17/09, noted the mechanical lift stored in the corridor by the</p>				

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