

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 655578	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/06/2015
NAME OF PROVIDER OR SUPPLIER HOLIDAY MANOR CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 20554 Roscoe Blvd, Winnetka, CA 91306-1746 LOS ANGELES COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	<p>a front wheel walker (FWW), and was at risk for bleeding due to the use of blood thinner, was provided with supervision and assistance to prevent fall and injury by falling to:</p> <ol style="list-style-type: none"> 1. Ensure Resident 1 was monitored for unassisted transfers and walking. 2. Ensure all nursing personnel caring for Resident 1 were aware of the resident's fall risk and the need to assist her with transfers and walking, re-direct her behavior of unassisted transfers/walking, and remind to call for assistance. 3. Implement the plan of care interventions to provide assistance and monitor Resident 1's gait disturbances. 4. Re-evaluate the plan of care to address Resident 1's continued episodes of independent transfers from the low-height bed and walking unassisted to develop additional interventions, such as bed and chair alarm, and to indicate the frequency of visual checks. 5. Implement the facility's policy and procedure on Prevention of Falls to use appropriate measures and instruments to prevent falls. 6. Implement the facility's policy and procedure on Fall, Risk For and Actual Fall to have further assessment, enhance the plan of care, minimize the risk for falls and improve communication with the necessary personnel. 		<ol style="list-style-type: none"> 2. To identify other residents who may have a potential to be affected by the findings outlined in the Complaint Investigation, the IDT has reviewed the plan of care of all residents who have been identified with a risk for falls. The IDT will continue to ensure that each resident's plan of care addresses the risks and provides approaches to minimize falls utilizing the least restrictive means possible. The plan of care will be reviewed as needed and at least quarterly. 3. The MDS designee received in-service training from the DON on 08/26/15 on the necessity of providing a clear description of the problems and approaches of residents who are at risk for falls including the need for updates at least quarterly and following any fall. <p>Provided in-service training on 09/08/15, 09/09/15, 09/13/15, 09/14/15 and 09/15/15 to the licensed and certified nursing staff on approaches to be utilized to minimize a resident's risk for falls. The Nursing staff will receive on-going in-service training as needed.</p>	12-1-15

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NAME OF PROVIDER OR SUPPLIER HOLIDAY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20654 Roscoe Blvd, Winnetka, CA 91306-1746 LOS ANGELES COUNTY		
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	<p>On 9/8/14, Resident 1 fell in her room near her bed, sustained a head injury, developed an intracranial hemorrhage (bleeding in the brain), and died on 9/17/14. The immediate cause of death was blunt force head trauma.</p> <p>A review of the closed clinical record indicated Resident 1 was admitted to the facility, on August 22, 2014, and was discharged on September 9, 2014, to a general acute care hospital (GACH). Resident 1's diagnoses included dementia (a progressive decline in memory and at least one other cognitive area, such as attention, orientation, judgement, abstract thinking and personality) with delirium (an acute disorder of attention, memory, and perception), muscle weakness, malaise (a general feeling of discomfort), and atrial fibrillation (irregular heart beat) which was treated daily with the blood thinner (anticoagulant) Coumadin (helps to prevent new blood clots from forming, and helps to keep existing blood clots from getting worse. This medicine increases the risk for bleeding).</p> <p>A care plan developed on August 22, 2014, for Resident 1's risk for falls and injuries related to her mental and physical conditions, included a low bed with half-length side rails, landing pads (fall safety cushion placed at the side of the bed for protection), assistance with transfer activities, monitor gait disturbance, and ambulation as desired with a FWW.</p> <p>A review of the Physical Therapy (PT) Evaluation and Plan of Treatment, dated August 23, 2014,</p>		<p>4. The facility will ensure proper communication and coordination among our staff during the start of the shift huddle with charge nurse and C.N.A's about any change of conditions. During daily stand up meeting with all Department heads, charge nurse's, and rehab personnel any change of condition and focus resident's due to risking behaviors are discussed for action and follow up. IDT team will ensure proper communication and coordination exists among all disciplines. Improvements or declines of a resident and interventions are discussed with responsible party. The DON shall inform the Quality Assurance committee at least quarterly of any findings and proper actions will be taken.</p>	12-1-15	

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	<p>indicated Resident 1 was referred for PT services due to new onset of decreased strength, functional mobility, transfers, ability to safely ambulate, neuro-motor control, and decreased postural alignment. The PT functional assessment indicated Resident 1 required one-person assistance with bed mobility, rolling, bridging, scooting, sitting, transfers, sit to stand, and stand pivot.</p> <p>The Fall Risk Evaluation form, dated August 25, 2014, indicated a score of 18. A total score of 10 or above represented a high risk for falls.</p> <p>A review of the Licensed Nurses Weekly Summary Report, dated August 31, 2014, indicated Resident 1 required supervision with transfers, limited one-person assistance with ambulation and bed mobility, extensive assistance with activities of daily living (ADLs) and toileting.</p> <p>A review of the Minimum Data Set (MDS - standardized assessment and care planning tool), dated September 4, 2014, indicated Resident 1 had severely impaired cognitive skills for daily decision-making, required one-person physical assistance with all her ADLs, including transfers and ambulation.</p> <p>The Fall Care Area Assessment (CAA - used to develop a resident-specific care plan based on identified problems, needs, and strengths), dated September 4, 2014, indicated the following: Resident 1 was prescribed psychotropic medications (mind altering medications) for</p>		<p>5. The Director of Nurses shall inform the Quality Assurance Committee at least quarterly of all falls occurring within the facility for a review of the facility's actions to minimize the risk for falls. All findings will be noted in the Quality Assurance Committee meeting minutes.</p> <p>6. Administrator, Director of Nursing, IDT, DSD, RN Supervisor, and Charge Nurses will monitor for compliance.</p>	12-1-15	

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	<p>psychosis (when a person has a break from reality, often involving seeing, hearing, and believing things that are not real - antipsychotic), anxiety (nervousness), and depression (persistent feeling of sadness and loss of interest). Resident 1 had impaired balance during transitions and walking, moving from seated to standing, walking with assistive device (front wheeled walker), moving on and off toilet, turning and facing opposite direction while walking, and doing surface to surface transfers. Resident 1 was considered at risk for injuries due to her diagnoses of dementia, psychosis, anxiety, abnormality of gait, blindness, and generalized weakness. She was described as forgetful, disoriented, and confused.</p> <p>The Psychotropic Medication Use CAA, dated September 4, 2014, indicated Resident 1 was at risk for falls/injuries due to her diagnoses of dementia, psychosis, anxiety, and depression.</p> <p>A review of the PT treatment notes, dated August 25, 26, 27, 28, 2014 and September 1, 2, 3, 4, 5, 2014 indicated there was no change in the resident's bed mobility and transfer abilities; Resident 1 required one-person assistance with bed mobility and transfers throughout her stay in the facility.</p> <p>The nursing Weekly Summary Report, dated September 7, 2014, indicated Resident 1 required supervision with transfers, limited one-person assistance with ambulation and bed mobility, and extensive assistance required with ADLs and toileting. This weekly summary report contradicted</p>				

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	<p>Resident 1's mobility and level of assistance from the MDS and PT assessments. There was no documentation by nursing staff to indicate the resident when attempting unassisted walking and transfers was re-directed and reminded to call for assistance to prevent falls.</p> <p>A review of the Nursing Assistant Daily Flow Sheet for August and September 2014 indicated Resident 1 was independent with bed mobility and ambulated on all shifts from August 22 to September 9, 2014. The documentation did not include the level of assistance required with walking/ambulation. For the 7 a.m. to 3 p.m. and the 3 p.m. to 11 p.m. shifts from September 1 to 9, 2015, the documentation indicated the resident was assisted with ADLs, but on the 11 p.m. to 7 a.m. shift documented the resident was independent with ADLs.</p> <p>A Licensed Nurses Progress Note by Staff 3, dated September 8, 2014, timed at 11:45 p.m., indicated Resident 1 was seen on the floor mat moaning, in a sitting position facing the door, noted with a bump on the right temporal (the side of the head behind the eyes), with the skin intact, and a bluish discoloration. The note indicated that with a certified nurse assistant (CNA), the resident was placed back in the bed, ice pack was applied on the right temporal area, and Tylenol 325 mg two tablets were given orally for pain. A complete body check was done and no other injury was found. At 12:10 a.m., Resident 1's physician was notified of the resident's fall and ordered an X-ray of the right</p>			

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	<p>temporal area, ice packs, and neurological checks. After the fall, Resident 1 was able to ambulate with a walker with a slow gait to the dining room.</p> <p>According to the following shift Licensed Nurses Progress Note dated September 9, 2014, timed at 7:30 a.m., Resident 1 ate 10% of her breakfast. At 7:45 a.m., the resident was noted with a lump/bump to the back of the head. At 8:30 a.m., the resident complained of pain to the right rib cage area while the X-ray was being taken. The attending physician was notified and ordered an X-ray of the right rib area. The result of a laboratory blood test ordered on September 2, 2014, obtained at 11:45 a.m. on September 9, 2014, indicated Resident 1's international normalized ratio (INR - used to monitor the blood thinning medication) was 5.28 (above the laboratory parameter for atrial fibrillation from 2.0 to 3.0 - an elevated INR indicates the blood is too thin and the person is at greater risk of bleeding). The attending physician was notified and ordered the resident to be transferred to the emergency room (ER) for evaluation.</p> <p>A review of the ER admission report, dated September 9, 2014, indicated Resident 1 was non-responsive on arrival, did not speak or open her eyes, and had some moaning sounds. A computerized tomography (CT scan - combines a series of X-ray images taken from different angles and uses computer processing to create cross-sectional images, or slices, of the bones, blood vessels and soft tissues inside the body) indicated the resident had a right-sided subdural</p>				

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	<p>hematoma (accumulation of blood on the brain's surface beneath the skull, usually resulting from head injury) with associated subarachnoid hemorrhage (bleeding in the area between the brain and the tissues that cover the brain, hemorrhage in this space can cause coma, paralysis, and death). The CT scan also indicated a left temporal parenchymal hemorrhage (bleeding within the brain itself) with associated left-sided subarachnoid hemorrhage.</p> <p>A review of the GACH discharge summary (from intensive care - ICU) to another hospital unit, dated September 13, 2014, indicated the physician recommended a nasogastric tube (special tube that carries food and medicine to the stomach through the nose) and intravenous nutritional support, but the family declined and decided to place the resident on hospice care for comfort measures only. Resident 1 expired at the GACH on September 17, 2014.</p> <p>A review of the Los Angeles City Coroners Report signed on September 23, 2014, indicated Resident 1 died on September 17, 2014 and the resident's death was caused by intracranial hemorrhage due to blunt force head trauma, resulting from a fall suffered at the facility on September 8, 2014.</p> <p>During an interview with Staff 4, the MDS coordinator, on August 10, 2015, at 4 p.m., she stated Resident 1 required limited assistance, meaning someone had to be with her to assist/guide her with ambulation and transfers.</p>			

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	<p>Staff 4 stated Resident 1 was not independent with ambulation and transfers.</p> <p>During an interview with the Director of Nursing (DON), on August 10, 2015, at 4:50 p.m., she stated Resident 1 was independent with ambulation and transfers.</p> <p>On August 31, 2015, at 7:45 a.m., during an interview with Staff 3, the nurse who found Resident 1 on the floor, he stated he made rounds on September 8, 2014, about 11 p.m. and Resident 1 was sleeping in bed. Staff 3 stated shortly after rounds, he heard moaning coming from the resident's room and found the resident sitting on the floor between the beds. Resident 1 had a blue-tinged bump on her right temple. Staff 3 stated Resident 1 was independent with ambulation and transfers and the resident had a low bed with floor mats. Staff 3 stated Resident 1 could not say what happened to her and also stated the resident routinely went to the bathroom by herself, unassisted, and did not use her call light. Staff 3 stated staff tried to provide visual checks frequently. Staff 3 could not explain why the assistance indicated in the MDS and care plan was not provided. Staff 3 did not document the resident was independent with transfers and walking.</p> <p>During an interview with Staff 2 (Physical Therapist), on August 31, 2015, at 11:15 a.m., she stated Resident 1 required minimal assistance with ambulation and transfers, which meant the resident required at a minimum, one-person assistance with ambulation and transfers. Staff 2 stated Resident 1</p>				

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	<p>was not independent with ambulation and transfers.</p> <p>According to the Accident/Incident Investigation form, dated September 10, 2014, on 9/8/14 at 11:45 p.m., the charge nurse (Staff 3) heard a loud 'bang' noise in Resident 1's room, immediately went to check and the resident was on the floor on a sitting position. The investigation report indicated Resident 1 ambulated with a walker, and was able to go to the bathroom independently.</p> <p>During an interview with Staff 5 (CNA), on September 25, 2015, at 11:45 a.m. and a review of the Nursing Assistant Daily Flow Sheets for Resident 1, she explained the forms were incomplete and the CNAs were to document the resident's mobility status and the level of assistance provided.</p> <p>The facility's policy and procedure titled, "Prevention of Falls," revised April 16, 2012, indicated it was the policy of the facility to assess residents for falls and to use appropriate measures to prevent falls. The policy indicated every effort was utilized to prevent falls and, if a resident was identified as at risk for falls, an appropriate instrument of prevention was put in place.</p> <p>The facility's policy and procedure titled, "Falls, Risk For and Actual Fall," revised April 16, 2012, indicated following the completion of the MDS, if a resident triggers a risk for falls, the resident would have further assessment. The plan of care would be</p>			

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	<p>enhanced, if indicated, to further minimize the risk for fall and improve communication with the necessary personnel. There was no documented evidence the plan of care was re-evaluated/ revised since Resident 1's admission to ensure the staff interventions were appropriate based on the resident's needs.</p> <p>The facility failed to ensure Resident 1, who was assessed as high risk for fall and injury due to confusion, impaired vision, physical limitations, unstable balance, medication use, in need of one-person assistance for transfer and walking with the use of a front wheel walker (FWW), and was at risk for bleeding due to the use of blood thinner, was provided with supervision and assistance to prevent fall and injury by failing to:</p> <ol style="list-style-type: none"> 1. Ensure Resident 1 was monitored for unassisted transfers and walking. 2. Ensure all nursing personnel caring for Resident 1 were aware of the resident's fall risk and the need to assist her with transfers and walking, re-direct her behavior of unassisted transfers/walking, and remind to call for assistance. 3. Implement the plan of care interventions to provide assistance and monitor the Resident 1's gait disturbances. 4. Re-evaluate the plan of care to address Resident 1's continued episodes of independent transfers from the low-height bed and walking unassisted to develop additional interventions, such as bed and 				

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	<p>chair alarm, and to indicate the frequency of visual checks.</p> <p>5. Implement the facility's policy and procedure on Prevention of Falls to use appropriate measures and instruments to prevent falls.</p> <p>6. Implement the facility's policy and procedure on Falls, Risk For and Actual Fall to have further assessment, enhance the plan of care, minimize the risk for falls and improve communication with the necessary personnel.</p> <p>On 9/8/14, Resident 1 fell in her room near her bed, sustained a head injury, developed an intracranial hemorrhage (bleeding in the brain), and died on 9/17/14. The immediate cause of death was blunt force head trauma.</p> <p>The above violation presented either an imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result, and were a direct proximate cause of death of Resident 1.</p>			

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REQUEST FOR LEGAL ACTION

The licensee of a long-term health care facility has 15 business days after issuance of the citation to notify the district office of its intent to file an action in Superior Court.

To request for legal action, please check the box below:

I wish to refer the citation to Superior Court. In accordance with Health and Safety Code section 1428, this constitutes written notice of my intent to do so. I will file a civil action within 90 calendar days of the postmarked date of this request. If I fail to do so, the citation shall be deemed a final former order of the State Department of Public Health.

HOLIDAY MANOR CARE CENTER
20554 Roscoe Blvd
Winnetka, CA 91306-1746

92-2068-0011776-F

Facility

Citation Number



818-341-9800

12/1/15

Signature of Licensee or Administrator

Telephone Number

Date

If any of the above boxes are checked, please send this form by certified mail within 15 business days to:

Department of Public Health
Licensing & Certification Program
L.A. County North District Office
15643 Sherman Way, Suite 200
Van Nuys, CA 91406