

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/27/2008
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NAME OF PROVIDER OR SUPPLIER LEMON GROVE CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8351 BROADWAY, LEMON GROVE, CA 91945 SAN DIEGO COUNTY
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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 -- PATIENT CARE 09-1925-0005704-F Complaint(s): CA00145400</p> <p>CFR 483.25(h)(2) Each resident receives adequate supervision and assistive devices to prevent accidents.</p> <p>The facility failed to provide adequate supervision to ensure the safety of one skilled nursing resident who smoked in the facility's designated smoking area (gazebo). On 3/31/08 at 11:00 A.M., Resident A was out in the gazebo with 2 other residents to smoke. There were no staff members or responsible adults present in the gazebo to assist, monitor, or supervise the residents. Resident A pulled [REDACTED] nylon jacket over [REDACTED] head to block the wind as [REDACTED] lit [REDACTED] cigarette. [REDACTED] nylon jacket caught on fire and the flames quickly spread to [REDACTED] hair and upper body. [REDACTED] sustained second degree burns (blistering of the affected skin with pain) and third degree burns (white and red areas involving deep tissues) to [REDACTED] face, head, neck, chest, upper arms, and fingers. [REDACTED] was transferred to the acute hospitals' trauma burn unit for treatment of 2nd & 3rd degree burns to 20 % (percent) of [REDACTED] body. On 4/10/08, ten days after the incident, Resident A died at the hospital from</p>			
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Event ID:4K1N11

1/26/2009

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	<p>Continued From page 1</p> <p>cardiogenic shock due to multiple myocardial infarctions and ongoing ischemia secondary to 20 percent total body surface area burn. The death certificate listed Resident A's immediate cause of death as "Complications of thermal burns."</p> <p>On 4/1/08 at 9:22 A.M., the Director of Nurses (DON) sent a letter to the Department to report that on 3/31/08, Resident A caught on fire while smoking in the smoking patio. The report read in part; "Yesterday at about 11:00 A.M., (Resident A's last name) was out on the smoking patio. ■■■ related the following, "I was trying to light my cigarette and I pulled my jacket up to block the wind..." At some point, (Resident A) jacket caught fire. The receptionist noted smoke and flames coming from the smoking area and saw the resident's torso engulfed in flames. The receptionist called for staff assistance, pulled the fire alarm and called 9-1-1."</p> <p>An onsite visit was conducted at the facility on 4/2/08 at 7:30 A.M.</p> <p>A review of Resident A's medical record was conducted on 4/2/08 at 8:00 A.M.</p> <p>Resident A was a 74-year old ■■■ who was admitted to the facility on 7/25/07, with diagnoses that included ■■■ and memory loss, per the Record of Admission. The admission minimum data set (MDS) assessment dated 8/10/07, indicated that</p>			

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	<p>Continued From page 2</p> <p>Resident A required extensive assistance (staff performed part of the activity for the resident) in performing activities of daily living such as turning from side-to-side when lying in ■ bed, transferring to/from bed or wheelchair, putting on or taking off clothing, transferring on/off toilet, and combing ■ hair or brushing ■ teeth.</p> <p>The Activity Assessment Form dated 8/8/07 indicated that Resident A's preferred primary activity was smoking in ■ room and in the patio/gazebo. The same assessment indicated that Resident A needed assistance to perform the activity (smoking) while out on the patio.</p> <p>The plan of care dated 8/10/07 identified that Resident A smoked daily and had potential for injury related to smoking. The care plan interventions included the following:</p> <ol style="list-style-type: none"> 1. Explain facility smoking policies to resident. 2. Monitor resident to assess compliance with facility smoking policy. 3. Repost incidents of non-compliance to supervisor. 4. Evaluate the need for removal of smoking materials. <p>The initial Smoking Safety Screening assessment dated 8/10/07, contradicting the above plan of care, indicated that Resident A could smoke without restrictions.</p> <p>On 11/21/07, Resident A was found smoking in</p>			
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	<p>Continued From page 3</p> <p>the patio outside ■■■ room, which was a non-designated smoking area. The facility intervened by moving the resident to another room with no outside access, and then completed another Smoking Safety Screening assessment on 12/11/07. This time, the facility identified that Resident A required "constant reminders to smoke only in designated areas." There were no other interventions such as staff monitoring or supervision to ensure that Resident A remained safe, and in compliance with the facility's smoking policy.</p> <p>On 4/2/08 at 8:20 A.M., the facility's Incident/Accident Report (IAR) dated 3/31/08 was reviewed. The report read as follows:</p> <p>"Resident A was outside in smoking area under gazebo. ■■■ was attempting to light ■■■ cigarette. It was very windy, so ■■■ lifted ■■■ jacket around ■■■ head. ■■■ jacket caught fire and the resident was engulfed in flames from the lower abdomen up, including torso, arms, and head. The receptionist saw something burning in the patio under (the) gazebo, called to activity person and pulled the fire alarm. PT (physical therapist) ran to the area and removed resident's shirt. Housekeeper extinguished flames with a towel. Paramedics on scene and took over care of the resident. Administrator also put out flames with fire extinguisher. Resident transported by paramedics/Fire Department to (hospital's name) ER (emergency room) burn center. O2 (oxygen) saturation 96% (percent), pulse rapid</p>			

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	<p>Continued From page 4</p> <p>@ 111."</p> <p>On 4/2/08 at 10:00 A.M., Resident C (witness) was observed and interviewed. ■ was alert, attentive, and spoke clearly. ■ stated that on 3/31/08 at around 11:00 A.M., ■ was in the gazebo to smoke with 2 other residents (Resident A and Resident B). Resident C stated that it was "very windy" that day. ■ stated that there were no staff members in the gazebo. ■ stated that Resident A lifted ■ jacket over ■ head to block the wind while ■ lit ■ cigarette. ■ stated, "All of a sudden, ■ jacket was on fire and spread to ■ head. I yelled for help and tried to put the fire out with my hands. I burned the tips of my fingers. It took at least 5 minutes before staff came to the gazebo." Resident C stated, "Staff does not come out to the gazebo to monitor or assist us when we smoke."</p> <p>On 4/2/08 from 10:30 A.M. to 11:45 A.M, the following staff members were interviewed:</p> <p>Housekeeper 1 (H 1) was interviewed through an interpreter. H 1 stated, "On 3/31/08 at 11:15 A.M., I was mopping the floor in the front lobby area near the nurses' station 1. I happened to glance out the glass sliding door which led to the patio area. I saw smoke and flames under the gazebo where residents were smoking. I yelled in Spanish, "demen una tuwalya!" (Get towels!), but no one understood what I was saying. I grabbed a small towel from my cart and ran out to the patio. The (Resident A) hair</p>			

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	<p>Continued From page 5</p> <p>was on fire! I patted [redacted] head with the small towel."</p> <p>The physical therapist 1 (PT 1) stated, "I was at the nurses' desk in station 1 when I heard two people yell, "Call 9-1-1! I ran to the front of the sliding glass door and saw a [redacted] (Resident A) in the gazebo who was engulfed in flames. I ran outside and ripped [redacted] jacket from [redacted] upper torso. Other staff members came out to help. The flames were put out before the paramedics arrived."</p> <p>On 4/8/08 at 3:15 P.M., a second visit was made to the facility. During this visit, Resident B was observed and interviewed. [redacted] was alert and spoke clearly. When asked of what [redacted] remembered about the burn incident on 3/31/08, Resident B stated that [redacted] was out in the gazebo smoking with 2 other residents (Resident A and Resident C). [redacted] stated that it was "very windy" that day. [redacted] stated that there were no staff members in the gazebo to check on them or to help them if needed. [redacted] stated that Resident A pulled [redacted] black nylon jacket over [redacted] head to block the wind while [redacted] lit [redacted] cigarette. [redacted] stated, "The jacket burst into flames and [redacted] started to burn. I yelled for help! It was a few minutes later before someone came out to the gazebo with an extinguisher."</p> <p>On 5/1/08 at 9:42 A.M., a third visit was made to the facility. During this visit, the receptionist was interviewed. [redacted] stated; "On 3/31/08 at</p>			

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	<p>Continued From page 6</p> <p>11:15 A.M., I was walking past Station 1 to the front desk in the lobby area when I happened to glance towards the sliding glass door. I saw thick smoke rising upward towards the top of the palm trees. I back-tracked and followed the source of the smoke until I saw flames coming from the gazebo! There were 3 residents there and I thought to myself, what are they burning? I did not go out to the patio to check, but I walked towards the social services office. Before I got there, I looked back and saw that the flames were getting bigger. I saw that one of the three residents (Resident A) was engulfed in flames and was shaking from side-to-side. I then pulled the fire alarm and immediately called 9-1-1."</p> <p>On 5/1/08 at 11:00 A.M., staff members were interviewed to determine what the facility's policies and procedures were regarding smoking, and how staff members supervised the residents who smoked in the gazebo. Each staff member responded as follows:</p> <p>The social service designee (SSD) stated, "The facility does not have scheduled smoking times. The residents can smoke anytime they want, without staff members or other persons supervising them."</p> <p>The licensed nurse 1 (LN 1) stated, "Visual supervision means that staff should be out in the gazebo with those residents who require supervision while smoking. Staff members are to make sure the residents are supervised and</p>				

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	<p>Continued From page 7</p> <p>to make sure that they have a smoking apron on. After the (burn) incident, staff members are now required to be out in the gazebo to monitor or supervise the smoking residents."</p> <p>The certified nurses' assistant 1 (CNA 1) stated, "Visual supervision means that staff were to stay out in the gazebo with the residents when they smoked. We have to make sure that the residents are safe and are wearing smoking aprons. We have to help them light their cigarettes if needed."</p> <p>The LN 2 stated, "Responsible persons such as the certified nurses' assistant, receptionist, or activities staff were supposed to watch the residents. If the residents were deemed unsafe to smoke on their own, a CNA was sent with them to the smoking area. Resident A, Resident B, and Resident C were supposed to be monitored or supervised based on their smoking assessment, but no one did."</p> <p>On 5/1/08 at 12:30 P.M., the distance from the reception area and the closest nursing station (Station 1) to the gazebo was measured to determine if staff members could provide "visual supervision" from inside the facility. The distance was 70 feet from the reception area to the gazebo and 60 feet from Station 1 to the gazebo. There was a sliding glass door 10 feet away from the reception area and on the left side of Station 1 that led out to the patio/gazebo. It was noted that staff members or anyone in the nursing station or by the</p>			

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	<p>Continued From page 8</p> <p>reception area could not view or see the gazebo or the smoking residents unless they walked by or stood in front of the sliding door.</p> <p>On 5/6/08 at 12:00 P.M., Resident A's [REDACTED] was interviewed by telephone. [REDACTED] stated; "I visited my [REDACTED] at least 6 times a week, from 3:00 P.M. to 6:00 P.M. We both smoked in the gazebo for 1 to 1 1/2 hours each time. I always lit [REDACTED] cigarettes for [REDACTED]. I never saw staff come out in the patio to help my [REDACTED] or to monitor any of the other residents who smoked in the gazebo. I was concerned with my [REDACTED] safety when I was not with [REDACTED] and there was no staff to supervise or help [REDACTED] when [REDACTED] smoked in the gazebo. There should've been staff in the gazebo when my [REDACTED] or the other residents smoked. I voiced my concerns to the facility during a care plan conference that I recently attended in 2/08. No one from the facility discussed what they would do regarding my concerns for my [REDACTED] safety when [REDACTED] smoked without staff supervision."</p> <p>On 5/15/08 at 9:00 A.M., the following documents regarding Resident 1's burn incident were reviewed:</p> <p>The emergency medical transport report dated 3/31/08 read as follows: "Incident date 3/31/08 11:00. Call received 11:20, Responding 11:21, Arrived scene 11:25, Departed scene 11:38, Arrived Destination 11:54. C/C (chief complaint) severe burns. HX (History)-Patient was sitting in [REDACTED] electric scooter outside</p>			

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	<p>Continued From page 9</p> <p>courtyard under gazebo structure when [REDACTED] was lighting a cigarette and pulling up [REDACTED] jacket (apparently of flammable material) as a windbreak which ignited jacket and remainder of clothing. Clothing burned off onto ground leaving only adult diaper partially melted on pt (patient). Staff used fire extinguisher to extinguish flaming clothing. Staff applied towels and placed on O2 (oxygen) n/c (nasal cannula). AX (assessment)-found sitting on scooter under gazebo. Upholstery of seat and side rails partially melted. Physical exam reveals major burns including appx (appendages), singed scalp hair, singed nasal hair and black soot in nares (nostrils), 2nd & 3rd degree burns anterior torso, 1st/2nd degree burns both arms, 2nd/3rd degree burns left thigh, fingernails [REDACTED] [REDACTED] melted. Patient states pain 8 out of 10, MS (morphine sulfate) 10 mg. (milligrams) administered w/o (without) change in pain."</p> <p>The acute hospitals' Discharge Summary Report dated 4/15/08 was reviewed on 5/15/08 at 10:00 A.M. The report read in part; "This is a 74-year old [REDACTED] who sustained a 20 % burn to [REDACTED] anterior torso when [REDACTED] was trying to light a cigarette and the jacket that [REDACTED] was wearing caught on fire. An elective intubation (a tube inserted into a hollow organ or body passage) was carried out. On 4/4/08, the patient had debridement of [REDACTED] burns. [REDACTED] e was transferred to the burn intensive care unit (ICU). On 4/9/08, the patient's systolic blood pressure started to drop to the 70's. [REDACTED] blood pressure continued to fall and [REDACTED] eventually became</p>			
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Event ID:4K1N11

1/26/2009

1:10:39PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/27/2008
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NAME OF PROVIDER OR SUPPLIER LEMON GROVE CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8351 BROADWAY, LEMON GROVE, CA 91945 SAN DIEGO COUNTY
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	<p>Continued From page 10</p> <p>asystolic (asystole is a state of no cardiac electrical activity; hence no contractions of the heart and no cardiac output or blood flow). A chemical code was carried out but was unsuccessful. [REDACTED] was declared dead on 4/10/08 at 4:29 P.M."</p> <p>The facility did not provide for the safety of Resident A who was deemed to require monitoring while smoking. Staff members disclosed in interviews that the facility did not have designated smoking hours, and did not have staff members assigned to monitor, supervise, or assist the residents who required supervision or monitoring when they smoked. Resident A required extensive assistance in completing daily living tasks. [REDACTED] was confused, had decreased safety awareness, and was non-compliant with the facility's smoking policy; and yet, the facility did not provide preventative measures such as routine or random monitoring by staff to ensure the resident's safety. Resident A had set [REDACTED] on fire and sustained serious and life-threatening burns to 20 percent of [REDACTED] body because there were no staff members in the gazebo to assist [REDACTED] light [REDACTED] cigarette when it was windy; and, to immediately come to [REDACTED] rescue when [REDACTED] flammable nylon jacket caught on fire. Consequently, Resident A sustained 2nd & 3rd degree burns to 20 percent of [REDACTED] body. [REDACTED] died on 4/10/08, ten days after the incident, from cardiogenic shock due to multiple myocardial infarctions and ongoing ischemia secondary to 20 percent total body surface area burn. The certificate of death dated</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/27/2008
NAME OF PROVIDER OR SUPPLIER LEMON GROVE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8351 BROADWAY, LEMON GROVE, CA 91945 SAN DIEGO COUNTY		
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	<p>Continued From page 11</p> <p>7/15/08 listed Resident A's immediate cause of death as "Complications of thermal burns."</p> <p>This violation presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result and was a direct proximate cause of the death of the resident.</p>				

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