

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555764 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/31/2008 |
| NAME OF PROVIDER OR SUPPLIER PALOMAR HEIGHTS CARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1260 E OHIO STREET, ESCONDIDO, CA 92025 SAN DIEGO 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>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit.</p> <p>Representing the Department of Public Health:</p> <p>CLASS AA CITATION -- SUPERVISION 08-1276-0004630-F Complaint(s): CA00132860</p> <p>CFR <input type="checkbox"/>483.25 (h) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>The facility staff failed to provide adequate supervision and interventions to prevent one confused resident from eloping from the facility, undetected by the facility staff, which resulted in the death of the resident after she was stuck by an automobile.</p> <p>On November 21 and 22, 2007, between 11:45 P.M. and 12:33 A.M., Resident A eloped from the facility undetected. Resident A was struck and killed by an automobile at 12:33 A.M. in a four lane highway.</p> <p>Resident A's medical record was reviewed on 11/26/07. Resident A was a 94 year old female that was readmitted to the facility on 11/3/06 with the diagnosis of senile dementia per the admission face sheet. The attending physician had determined and documented on a history and physical dated 11/22/06, that Resident A did not have the capacity</p> | | | |

Event ID:SQOZ11

1/7/2009

2:09:41PM

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

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(X6) DATE

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| | <p>Continued From page 1</p> <p>to understand and make decisions. Additional assessments completed by the licensed nursing staff using the Minimum Data Set (MDS) assessment and dated 10/30/07, provided that Resident A had long and short term memory problems and impaired cognitive skills. The MDS also assessed Resident A as able to walk independently and was independent with many other aspects of daily living.</p> <p>Licensed Nurse (LN) 3 was interviewed on 11/26/07 at 2:00 P.M. and the medical record was jointly reviewed. Resident A had a history of wandering and attempting to leave the facility that dated back to the most recent admission to the facility on 11/3/06. The most current care plan, titled Wander/Elopement Risk, had been reviewed and rewritten on "10/23/7". Care planning interventions included reinforcing to the resident that she was not to leave the facility, redirecting the resident when needed, and the use of a Wanderguard bracelet (an alarm system by which a bracelet activator was attached to the limb of a person and when the person approached or crossed the Wanderguard doorway threshold an audible alarm should sound alerting staff).</p> <p>According to nursing notes dated 11/21/07, Resident A became agitated and began wandering the facility. Resident A had at least two documented episodes on 11/21/07 where staff had to intervene. The facility staff was prompted by alarms that alerted them to Resident A's attempts to exit the building. The first attempt resulted in a licensed nursing intervention documenting that</p> | | | |

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| | <p>Continued From page 2</p> <p>Resident A would be observed every 15 minutes. As documented in the nursing notes, "Initiated 15 min check due to increased agitation. Monitor for safety, wandering, checking other patient's doors". The intervention was started at 8:00 P.M., and the last documented 15 minute check/observation was at 11:45 P.M. Nursing notes provided that at 9:30 P.M., Resident A activated the alarmed door in the physical therapy area, requiring staff intervention that redirected Resident A back to her room. Nursing notes dated 11/21/07 at 11:40 P.M., indicated that Resident A was medicated and "will continue to monitor". The last documented time that the facility staff could account for Resident A was in the medical record at 11:45 P.M.</p> <p>The last narrative nursing note by LN 1 was dated 11/22/07 at 1:00 A.M. and accounted for the missing resident, the facility staff search and the contact with police at the accident scene. LN 1 confirmed during an interview on 12/4/07 at 7:00 A.M., that the nursing note was incomplete and unsigned.</p> <p>The local law enforcement accident report, dated 11/22/07, had interviews documented with LN 1 from the accident scene. LN 1 was quoted in the accident report to have stated, "Sometime between 0100 (1:00 A.M.) and 0130 (1:30 A.M.), P-2 [Resident A] was discovered missing during a bed check". The report also provided, "The Medical Examiner noted to LN 1 and the other staff members that the traffic collision was phoned into the police at 0033 hrs. (12:33 A.M.)." He noted that LN 1 "reported to me that P-2 [Resident A] was last</p> | | | |

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| | <p>Continued From page 3</p> <p>seen in her bed at 0045 hrs (12:45 P.M.), and discovered missing between 0100 and 0130 hours. LN 1 and the staff members were unable to provide a [sic] immediate reason for the discrepancy."</p> <p>During an interview with LN 1 on 12/4/07 at 7:00 A.M., LN 1 acknowledged that she had primary care oversight for Resident A. LN 1 stated that when she arrived at the accident scene on 11/22/07, the medical examiner removed the Wanderguard bracelet from the body and "gave it to me". LN 1 stated that when she returned from the accident scene she had entered the front door which is imbedded with the Wanderguard alarm system. LN 1 stated that the Wanderguard system did not activate as she moved through the front door alarm perimeter on 11/22/07.</p> <p>During an inspection of the facility on 11/26/07 at 11:45 A.M., all the alarmed entrances and exits tested positive for audible noises associated with the alarm response. The resident rooms with sliding glass doors that opened onto the outside of the facility were observed to have stop devices that allowed the doors to be opened only 6 inches wide. Administrative Staff could not ascertain if all alarmed entrances and exits were working on 11/22/07.</p> <p>During an extended interview with Administrative Staff on 11/26/07 at 1:30 P.M., the issue of how Resident A was able to leave the building undetected remained unsolved.</p> <p>According to the Administrative Staff, Resident A had on the Wanderguard bracelet mechanism that</p> | | | |

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| | <p>Continued From page 4</p> <p>should have activated an alarm upon exiting 2 of the potential exits. The remaining 5 exit doors were equipped with alarm key pads, which alarmed when the doors were opened.</p> <p>Resident A eloped from the facility undetected by facility staff on 11/21/07 sometime after 11:45 P.M. Resident A was struck and killed by an automobile at 12:33 A.M. on 11/22/07 as she was walking in the middle of a lane of a four lane highway. The facility staff failed to provide adequate supervision that was consistent with the needs, goals, and plan of care for Resident A. Resident A was able to wander away from the facility unnoticed by facility staff and onto a busy 4 lane highway, which presented an imminent danger to Resident A and was a direct proximate cause of the death of Resident A from injuries sustained when she was struck by an automobile.</p> | | | | |

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