

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056153	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/15/2007
NAME OF PROVIDER OR SUPPLIER Beverly LivingCenter - Napa		STREET ADDRESS, CITY, STATE, ZIP CODE 705 TRANCAS ST., NAPA, CA 94558 NAPA 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: [REDACTED]</p> <p>CLASS AA CITATION -- PATIENT CARE 11-1871-0004222-F Complaint(s): CA00090407</p> <p>F323 §483.25(h)(1) ACCIDENTS</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible.</p> <p>F324 §483.25(h)(2) ACCIDENTS</p> <p>The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>The facility violated the above regulations and failed to maintain and ensure the safety of Resident 1's wheelchair and failed to provide supervision to Resident 1 in the use of the wheelchair to prevent accidents. As a result, Resident 1 suffered a head injury and subsequent death after a fall from the wheelchair.</p> <p>Resident 1 was an 85 year old male, admitted to the facility on 1/5/06 with diagnoses that included dementia, stroke, and history of seizures. The Minimum Data Set (MDS) assessment indicated Resident 1 had short and long term memory problems with moderately impaired cognitive skills.</p>			

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11/28/2007

4:54:10PM

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	<p>Continued From page 1</p> <p>Resident 1 used a Fly-Weight transport wheelchair for locomotion.</p> <p>The rehabilitation short term care plan dated 3/10/06 and developed by occupational therapy (OT), indicated Resident 1 had poor postural wheelchair positioning and would tolerate sitting in a modified wheelchair to increase symmetry and proper wheelchair positioning.</p> <p>The OT evaluation dated 3/10/06, indicated that Resident 1 had poor attention span, poor safety awareness, and poor judgment.</p> <p>The OT notes dated 3/18/06, indicated OT staff evaluated Resident 1 for proper wheelchair positioning in the resident's current Fly-Weight transport wheelchair. The OT note indicated Resident 1 leaned back and pushed the wheelchair around the facility with his feet, but was not able to follow instructions for safety related to dementia.</p> <p>The OT notes dated 4/10/06, indicated, "D/C (discharge) Summary: Patient has sufficiently been provided positioning techs. [techniques] for safety in use of w/c [wheelchair], using positioning aids and also safety awareness training. CNA training completed." This was in contrast to the earlier assessments that the resident had poor safety awareness and was not able to follow instructions related to safety.</p> <p>A plan of care, dated as initiated 1/5/06, indicated Resident 1 had a potential for falls related to stroke and cognitive deficits and required total care. An undated, handwritten note in the care plan indicated the resident slid down in the wheelchair and tried to</p>			
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	<p>Continued From page 2</p> <p>wiggle down between the lap tray and chair in an attempt to get up. Interventions included for staff to observe the resident for signs and symptoms of functional decline and refer to OT and physical therapy (PT) as needed. Undated, handwritten notes in the care plan indicated interventions for a transfer pole, a wheel chair clip alarm, a non-slip cushion in the wheelchair to prevent slipping, and a soft waist belt restraint when the resident was in the wheelchair. There were no interventions that directed staff to keep the wheelchair brakes unlocked or locked when the resident was in the wheelchair.</p> <p>There was no documentation that addressed the appropriateness of using the Fly-Weight transport wheelchair for Resident 1, who had an assessment of poor safety awareness, and a history of leaning back in the wheelchair while self-propelling in the wheelchair.</p> <p>During an interview on 8/18/06 at 1:15 p.m., Administrative licensed staff stated on 8/16/06 at approximately 3:30 p.m., Resident 1 fell backwards in his wheelchair. Certified Nursing Assistant (CNA) B was in the room at the time, but did not witness the actual fall. According to Administrative licensed staff, the resident had a, "goose egg," lump on the back of his head following the incident, but otherwise was, "fine," and ate dinner that evening. She stated staff assessed and performed serial neurological checks on the resident and notified the physician. Administrative licensed staff stated that for the first 8 to 10 hours, the resident's neurological evaluations were normal. In the early morning of 8/17/06, staff noticed the resident was not responsive and had vomited. Paramedics transferred the resident to the local acute care hospital. The resident was diagnosed with an</p>			
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	<p>Continued From page 3</p> <p>intracranial bleed (bleeding within the skull) and was subsequently airlifted to another acute care hospital that could provide a higher level of care for the resident.</p> <p>During an interview on 8/18/06 at 2:00 p.m., OT staff stated the resident had used the Fly-Weight transport wheelchair since admission to the facility in January of 2006. The resident had left sided weakness as a result of a previous stroke and was unable to self propel with his hands. The resident self propelled the Fly-Weight transport wheelchair using his feet. The resident's transport wheelchair had four small wheels, with only two rear brakes, each with a separate locking mechanism.</p> <p>OT staff stated that transport wheelchairs were not intended for residents who self propelled themselves in a wheelchair and stated that theoretically, if the brakes were engaged, that may have caused the resident to tip when the resident pushed backwards. OT staff stated Resident 1 and another resident in the facility were the only two residents in the facility that had used transport wheelchairs for self propelling. OT staff stated that following Resident 1's accident, staff placed Resident 1, and the other resident who used a transport wheelchair, into more appropriate wheelchairs.</p> <p>On 8/18/06 at 2:15 p.m., Resident 1's transport wheelchair (Fly-Weight Transport chair by Drive Medical) was inspected. The right rear wheel brake did not remain locked when the wheelchair was moved, but the left brake remained fully engaged. There were no anti-tip bars installed on the wheelchair. During concurrent interview, OT staff acknowledged the right rear brake gave away and</p>			

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	<p>Continued From page 4</p> <p>stated maintenance staff was responsible for performing safety checks on the wheelchair. OT staff did not know if the facility had a manufacturer's manual and stated that the wheelchair was old and that Resident 1's family brought the wheelchair from home. She stated the resident had used that wheelchair since admission to the facility.</p> <p>During an interview on 8/18/06 at 2:30 p.m., CNA A stated that on 8/16/06, before dinner, CNA B asked for help to assist Resident 1 into the wheelchair. CNA A held the back of the wheelchair while CNA B transferred the resident from the bed to the chair. CNA A stated the resident had a soft waist belt on when in the wheelchair due to the resident's history of slipping out of the wheelchair. CNA A stated the resident did not use a lateral support cushion. CNA A stated he never locked Resident 1's wheelchair because the resident was able to self propel the wheelchair with his feet. CNA A then assisted CNA B with Resident 1's roommate and left the room. A few minutes later CNA A heard CNA B call for help. CNA A went into the room and saw that Resident 1, still strapped in the wheelchair, had tipped backwards in the wheelchair. CNA A stated the resident was able to talk and was responsive following the accident.</p> <p>CNA A stated the next morning, on 8/17/06 at approximately 6:30 a.m., he went into Resident 1's room to get the resident up for a shower. The resident was sleeping deeply and made loud snoring noises. CNA A was unable to awaken the resident. CNA A said that was unusual because the resident usually awoke easily. CNA A informed the licensed nurse, who went into the room and thought the resident was probably just in a deep sleep. The licensed staff left the room.</p>			
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	<p>Continued From page 5</p> <p>CNA A stated approximately 15 minutes later, he went into the resident's room and noticed a few teaspoons of dark blood on the resident's chin. CNA A was again unable to awaken the resident and the resident continued to snore loudly. The licensed staff was also unable to arouse the resident. Licensed staff called 9-1-1 (emergency services). Paramedics arrived and transported Resident 1 to the acute care hospital.</p> <p>The clinical record indicated that on 8/17/06 at 7:00 a.m., the licensed nurse documented the CNA reported that the resident had vomited a small amount, dark brownish in color. Licensed staff paged the nurse practitioner and did not receive a response. The licensed nurse called the clinical after hour's advice line and received orders to call 9-1-1. At 7:15 a.m., the licensed nurse documented the paramedics arrived and transferred the resident to the hospital.</p> <p>The emergency response team worksheet, (incorrectly) dated 8/16/06 (date should reflect 8/17/06), documented the emergency response team received the 9-1-1 call at 7:24 a.m. on 8/16/06 and arrived at the facility at 7:29 a.m. The acute care hospital records documented the emergency response team transported the resident to the acute care hospital on 8/17/06.</p> <p>During an interview on 8/18/06 at 2:45 p.m., CNA B stated he transferred Resident 1 into his wheelchair with the assistance of CNA A. CNA B stated he locked the wheelchair prior to transferring the resident from the bed to the chair. CNA B stated Resident 1 had a soft waist belt restraint when in the wheelchair, because the resident had a history of slipping out of the wheelchair. CNA B stated the resident did not use</p>			
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	<p>Continued From page 6</p> <p>a lateral support cushion in the wheelchair, but had a non-slip cushion in the seat and also a wheelchair alarm. CNA B stated that, (contrary to CNA A's statement) he kept the wheels locked on the wheelchair because the resident was able to self propel the wheelchair with his feet and CNA B did not want Resident 1 to leave the room until the resident's roommate was up and prepared for dinner.</p> <p>When questioned regarding the location of Resident 1's wheelchair prior to the fall, CNA B stated he left the resident about one to two feet from the end of the bed, facing the door and went to care for the resident in the next bed. When asked if the resident would have been able to push his feet off of the wall, CNA B stated, "no." CNA B stated that while he attended to Resident 1's roommate, he heard a loud noise. CNA B turned and saw Resident 1 on the ground, backwards in the wheelchair. Resident 1 was still in his wheelchair, strapped in by the soft waist belt restraint. CNA B stated the resident had hit the back of his head on the floor, but was still talking and seemed alert after the fall. CNA A and a licensed staff arrived and put the resident upright in the wheelchair. After the licensed staff assessed the resident, CNA B put the resident into another wheelchair and went out to the dining room for dinner. CNA B stated the resident ate dinner well and seemed fine.</p> <p>CNA B stated about a month prior to the resident's fall from the wheelchair (on 8/16/06), CNA B took Resident 1 into the dining room and locked the two rear wheels on the resident's wheelchair. CNA B noticed that Resident 1 pushed backwards in the wheelchair and started to tip backwards. CNA B went to the resident and prevented the wheelchair from tipping. CNA B stated he did not report this incident to</p>			
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	<p>Continued From page 7</p> <p>anyone.</p> <p>During an observation and interview on 8/18/06 at 3:10 p.m., administrative licensed staff noted the right rear wheel brake on Resident 1's Fly-Weight transport wheelchair did not remain locked with movement and did not know if maintenance records were available for the wheelchair. Administrative licensed staff stated the facility did not have the manufacturer specifications or owner's manual for the wheelchair because the family brought the wheelchair from home when the resident was admitted in January, 2006.</p> <p>During an interview and concurrent observation on 8/18/06 at 3:20 p.m., PT staff noted the right wheel on the resident's wheelchair did not remain locked with movement and the left wheel remained locked. PT staff stated the wheelchair was safer when it was not in a locked position because the resident knew how to self propel in the wheelchair. PT staff stated staff should not have locked the resident's wheelchair. PT staff did not respond when asked if the wheelchair was unstable if one wheel remained locked, while the other wheel's brake disengaged with movement.</p> <p>During an interview on 8/18/06 at 3:55 p.m., PT staff stated a modified wheelchair, referred to in the short term care plan dated 3/10/06, meant to add something to the resident's existing wheelchair. PT staff stated the modification added to Resident 1's wheelchair was a lateral support cushion, which staff placed in Resident 1's wheelchair to improve the resident's posture while sitting in the wheelchair. There was no care plan intervention for the use of the lateral support cushion. PT staff stated the resident should have continued to use the lateral support cushion and did not know why that intervention was</p>			
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	<p>Continued From page 8</p> <p>not in the care plan. PT staff stated nursing staff were responsible for carrying out the OT recommendations.</p> <p>During an interview on 8/18/06 at 4:10 p.m., Licensed staff stated she was on duty when Resident 1 fell backwards in the wheelchair. Licensed staff stated the resident self propelled in the wheelchair, but was not aware of any prior incidents of Resident 1 tipping backward while in the wheelchair. The Licensed staff stated the resident had not used the lateral support cushion in quite some time because the resident didn't seem to need it anymore.</p> <p>Licensed staff stated after the accident, she put Resident 1 into a different wheelchair, which she believed was safer. Licensed staff stated that after Resident 1's accident, she sat in the resident's wheelchair, and locked the two rear brakes and noticed the left rear brake remained locked, but the right rear brake did not remain locked when she pushed the wheelchair with her feet. The wheelchair continued to rotate backward with movement. Licensed staff believed the wheelchair was unstable, was not safe, and could tip backwards. Licensed staff stated she made sure staff did not put that wheelchair back into the resident's room so staff would not put the resident in that wheelchair again.</p> <p>During an interview on 8/18/06 at 4:25 p.m., the Administrator stated maintenance staff performed routine wheelchair safety checks, but was not able to provide the wheelchair maintenance records. The Administrator stated the facility should not place residents in unsafe wheelchairs and staff needed to conduct assessments and implement appropriate safety devices to ensure residents used appropriate and safe wheelchairs.</p>			
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	<p>Continued From page 9</p> <p>On 8/28/06, the facility reported that the resident died on 8/22/06.</p> <p>The death certificate for Resident 1 documented the cause of death as: (A) SUBDURAL HEMATOMA (bleeding into the brain), (B) BLUNT FORCE INJURY OF HEAD. The cause of injury documented, "fall from wheelchair."</p> <p>The manufacturer's specification for a Fly-Weight Transport wheelchair indicated the Fly-Weight transport wheelchair was a lightweight wheelchair with a frame weight of 19 pounds, and was intended for short distances only. The smaller wheels required a care-taker to push the wheelchair of the user. Transport wheelchair users cannot propel themselves.</p> <p>During an interview on 12/18/06, a manufacturer's representative stated transport wheelchairs were not intended for self propelling by the user, but were intended for use by a second person to push the wheelchair user.</p> <p>In summary, the facility failed to provide an appropriate wheelchair for Resident 1, who was able to self propel in a wheelchair; failed to adequately supervise Resident 1 for wheelchair safety and develop appropriate interventions for Resident 1, with a known history of unsafe behavior and pushing back while self propelling in the wheelchair; and failed to ensure the wheelchair brakes were maintained and functioned properly, which led to instability of the wheelchair. These failures led to Resident 1 tipping over backwards in the wheelchair and suffering a blunt force injury to the head which resulted in a subdural</p>			
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Event ID:TRO311

11/28/2007

4:54:10PM

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: 056153	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/15/2007
NAME OF PROVIDER OR SUPPLIER Beverly LivingCenter - Napa		STREET ADDRESS, CITY, STATE, ZIP CODE 705 TRANCAS ST., NAPA, CA 94558 NAPA 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>Continued From page 10</p> <p>hematoma and death.</p> <p>These violations represented either an 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 patient.</p>			

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