

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>BROWNING MANOR CONVALESCENT HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>729 BROWNING ROAD, DELANO, CA 93215 KERN 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>CLASS AA CITATION -- PATIENT CARE 12-2073-0007407-F Complaint(s): CA00194032</p> <p>Representing the Department of Public Health: [REDACTED], HFE Sup</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>F323 - 483.25(h) - Free of Accident Hazards/Supervision/Devices</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>On July 17, 2009 at 12:50 PM, an unannounced visit was made to the facility to investigate a complaint regarding a death related to a fall incident occurred on June 23, 2009.</p> <p>Based on the interview and record review, the facility failed to provide necessary supervision and timely monitoring to a resident (Resident A) who exhibited aggressive behavior. The delay caused Resident A to fall forward from his wheelchair and sustained a fracture of cervical spine. Resident A was transferred immediately to an acute hospital</p>			

Event ID:WJXM11

8/6/2010

2:13:45PM

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

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	<p><b>Continued From page 1</b></p> <p>and died within two days.</p> <p>On July 17, 2009 at 2 PM, Resident A's clinical record was reviewed. Resident A was 58-years-old with combative behavior and resisting care. His cognition was moderately impaired. When in a high-back wheelchair (w/c), Resident A was placed on a tab alarm and a self-release belt restraint.</p> <p>On July 17, 2009 at 1 PM, during an interview, the Administrator stated Resident A was able to disconnect his tab alarm and self-release seat belt with alarm when he was in his high-back wheelchair. On June 23, 2009 at 7:15 PM, Resident A was sitting in his high-back wheelchair in front of the nurses' station. He had both a self-release belt restraint with safety alarm and a tab alarm at the time. She added that another resident, Resident B, witnessed the incident and "He (Resident B) is alert and he can tell you what happened."</p> <p>On July 17, 2009 at 1:05 PM, Resident B was interviewed. He stated that Resident A was about 2-3 feet in front of him. Resident A leaned forward with both arms out trying to grab something. Resident B stated he attempted to reach Resident A to prevent him from falling forward; but was unable to do so. "There was a couple of staff inside nurses' station. They were all surprised about his fall." Resident B could not remember who they were.</p> <p>On July 17, 2009 at 3:03 PM, during an interview, CNA (Certified Nursing Attendant) 1 stated she was</p>			
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	<p><b>Continued From page 2</b></p> <p>having her lunch break at the time. When she heard the alarm, she ran out of the break room and saw Resident A already on the floor. At 3:10 PM, CNA 2 stated Resident A was combative that evening. He disconnected his self-release belt and reconnected it behind him to prevent the alarm from going off. When she went to lunch at 7 PM, two nurses were with him to reconnect the self-release belt in front of him.</p> <p>At 3:25 PM, on July 17, 2009, in an interview, LN (Licensed Nurse) 1 stated on June 23, 2009, day shift staff reported to her that Resident A was very agitated throughout the day. "He kept on yelling and had his arms out." She said, "He could unbuckle his seat belt and hook it back behind him." At the time of his fall, she was in the medication room behind the nurses' station. When she heard the yelling, she opened the door and Resident A was already on the floor.</p> <p>On September 4, 2009 at 4:40 PM, during an interview, CNA 3 stated she was in Room 3 at the time of Resident A's fall. This room was at the midway point of the east wing. When she heard the alarm, she saw Resident A lean forward. She tried to run but could not get to him. CNA 3 stated Resident A, before the fall, was "fighting with nurses, taking off the alarm and the self-release belt." "When he gets agitated, the licensed staff would do one-on-one monitoring with him. It was done before." On September 9, 2009 at 2:25 PM, RN (Registered Nurse) 1 stated, "When someone with behavior outbursts, per facility policy and procedure is to place him on one-on-one</p>				

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	<p><b>Continued From page 3</b></p> <p>(monitoring)." She stated Resident A was placed on one-on-one monitoring before because of his agitated behavior.</p> <p>On July 17, 2009 at 11:20 AM, Resident A's clinical record was reviewed. His cognitive skills for daily decision making, according to the MDS (Minimum Data Set, a patient data collection tool) dated May 4, 2009, was moderately impaired. A review of the licensed nurses' progress notes, it indicated that Resident A had multiple episodes of behavior outbursts. For instance, on May 26, 2009 at 6:25 AM, a nurses' note read: "...very combative, trying to grab CNA and accidentally hit himself and sustained a skin tear..." On June 5, 2009 at 8 AM, a nurse documented: "...yelling at staff and stripping his shirt..." On June 10, 2009, another nurse wrote: "OOB (out of bed) to w/c (wheelchair)...started to yell at staff, stripping his shirt. Tried to swing at anybody who goes near him..." On June 17, 2009 at 5 AM, another entry read, "(with) episode of being restless in bed..." On June 19, 2009, a nurses' note revealed: "R (Resident A) on close monitoring due to episode of striking out." On the day of his fall incident, June 23, 2009 at 4 PM, LN 2 documented: "R is refusing to be changed. CNA said that R is combative trying to hit them. R kept in his w/c (wheelchair) and left unchanged." At 5 PM, she wrote: "R is restless-yelling..." At 6 PM, she wrote: "CNA reported to me that (Resident A) wants to get up &amp; body alarm keeps on going off. Instructed assigned CNA to bring (Resident A) to the nurses' station. R continue(d) to remove w/c belt. I talked to R calmly but he cont(inued) to yell and say 'no.' He then</p>			

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	<p><b>Continued From page 4</b></p> <p>cont(inued) to reach out on anybody that came closer to him. R is being observed closely and kept his w/c away from other residents along the hallway."</p> <p>During an interview on August 21, 2009 at 11:52 AM, LN 2 stated she was the charge nurse the day Resident A fell. "He was very upset and was bending over to pick up something from the floor" and "frequently reaching out for the rails or someone." LN 2 stated that when he (Resident A) became agitated, he would be put on one-on-one close monitoring. She explained that it had been the facility's normal practice when a resident became agitated. LN 2 was asked why one-on-one close monitoring was not initiated when Resident A exhibited aggression, She stated that she "I was going to call the Administrator after my lunch hoping he would calm down. And that happened."</p> <p>On August 21, 2009 at 3 PM, the facility's policy and procedure on "BEHAVIOR OUTBURST, MONITORING/SHADOWING" was reviewed. It read: "When a resident exhibits behavioral outbursts, the resident will be monitored for at least 72 hours for behavior problems, and if need be, he/she will be shadowed until the resident calms down, has no further outbursts in behavior and is no longer a risk to themselves or other residents." The "Procedure 1.d." read: "The charge nurse must report the incident immediately to the administrator and the D.O.N." And, the "Procedure 1.e." read: "The charge nurse will assign a staff member(s) to monitor/shadow the resident if needed." Further, Procedure 3, read, "The interdisciplinary team will</p>				

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	<p><b>Continued From page 5</b></p> <p>meet as soon as possible to review the resident and determine what action is to be taken..."</p> <p>On September 28, 2009 at 9:30 AM, Resident A's final coroner's report was reviewed. The Coroner documented: "Fell from wheelchair and sustained cervical fractures... (Resident A) suffered an occipital fracture and spinal fracture to C-2 and C-4." The cause of Resident A's death, as the coroner wrote: "was a direct result of injuries he suffered...The manner of death is accident."</p> <p>Therefore, the facility failed to provide one-on-one monitoring consistent with its policy to prevent Resident A from leaning forward when he exhibited aggressive and combative behavior earlier that day before his fall and had a history of becoming agitated. Consequently the fall directly led to his death directly.</p> <p>The violation of this regulation 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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