

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/26/2009
NAME OF PROVIDER OR SUPPLIER Golden LivingCenter - Shafter		STREET ADDRESS, CITY, STATE, ZIP CODE 140 EAST TULARE AVENUE, SHAFTER, CA 93263 KERN COUNTY	

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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 12-2210-0006570-S Complaint(s): CA00166813</p> <p>Representing the Department of Public Health: ██████████ HFEN</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>Title 22 DIV5 CH3 ART3-72311(a)(1)(C) Nursing Service-General</p> <p>(a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (C) Reviewing, evaluating and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition</p> <p>Based on interview and record review the facility failed to identify and assess the co-morbidity of an anticoagulant (blood thinning) medication and the pattern of falls, six within a ten month period, for Patient A which resulted in the Patient's death from a subdural hematoma.</p>		<p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements</p> <p>This plan of correction constitutes my written credible allegation of compliance for the deficiencies noted.</p> <p>This Plan of Correction shall constitute this facility's credible allegation of compliance.</p> <p>Title 22 DIV 5 CH3 ART3-72311</p> <p>Nursing service includes but is not limited to. 1. Planning of patient care including but not limited to: reviewing, evaluating and updating of the patient care plan as necessary by the nursing staff and other professional personal involved in the care of the resident at least quarterly and more often is there is a change in the patient's condition.</p>	

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Kathy Boyaf *Administrative* 3/02/10

[Signature] Division President 3/3/10

3/3/10 ABC accepted. JB

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	<p>Continued From page 1</p> <p>Findings:</p> <p>The clinical record for Patient A was reviewed on October 30, 2008 at 10 AM Patient A was admitted on December 10, 2007 with diagnoses that included senile dementia, senile and presenile psychotic conditions, diabetes, cardiac dysrhythmias, (an irregular heart beat,) and a past history of thrombosis, (a blood clot in a blood vessel.) Her medications included Warfarin. According to Lexi-comp, 2009 a clinical pharmacology reference guide, Warfarin is an anticoagulant, (slows blood clotting.) Contraindications, (not indicated) for the use of Warfarin read, "...AN UNRELIABLE, NONCOMPLIANT PATIENT WHO HAS A HISTORY OF FALLS OR IS A SIGNIFICANT FALL RISK; UNSUPERVISED SENILE OR PSYCHOTIC PATIENT." Warning/Precautions for the use of Warfarin read, "USE CARE IN THE SELECTION OF PATIENTS APPROPRIATE FOR THIS TREATMENT. ENSURE PATIENT COOPERATION ESPECIALLY FROM THE...DEMENTED PATIENT" The U.S. (United States) Boxed Warning for Warfarin read, "MAY CAUSE MAJOR OR FATAL BLEEDING."</p> <p>The Medical Record Review Summary provided by the Director indicated Patient A had multiple falls. The first fall was two days after admission on December 12, 2007; the 2nd fall March 4, 2008; the 3rd, 4th, and 5th falls, June 18, 20, and 26 of 2008; and the last fall October 19, 2008.</p> <p>During an interview with the DON (Director of</p>		<p>1. The resident no longer resides at the facility. 3, 9, 2010</p> <p>2. Other residents who are at risk for falls and take medications that increase risk for bleeding have the potential to be affected. Residents identified with increased risk for bleeding due to falls and anticoagulant drugs will have a pharmacy review of anticoagulant medication completed by 3.09.2010. After review, the attending physician will be notified by the Licensed Nurse of recommendations for treatment changes and follow up as indicated. DNS or RN designee will communicate the changes to the Licensed Nurses and CNAs as indicated. 3, 9, 10</p>

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	<p>Continued From page 2</p> <p>Nursing), on October 30, 2008 at 11 AM, she stated she was unaware if any safety devices were used for Patient A and that there was no system in place for a CNA (certified nursing assistant) to access that information, except for verbal report during change of shift between one CNA to another. She also stated she had not discussed the plan of care with Patient A's doctor regarding the multiple falls and the concurrent Warfarin medication and did not know if anyone had. When asked for the nursing notes of October 19, 2008 she stated the nursing notes from that date could not be found.</p> <p>During an interview with CNA 1 on October 30, 2008 at 10:30 AM, she stated Patient A was allowed to independently transfer herself from the bed to the wheelchair and to the toilet. She stated there were no safety devices used except a tab alarm, (a small box with an electronic wire that can be attached to a bed or wheelchair and to the patient), however Patient A didn't like it and always took it off. When asked if any other accommodation was made because Patient A did not wear the tab alarm she replied, "No".</p> <p>During an interview with LN (Licensed Nurse) 1 on October 30, 2008 at 10:45 AM, when asked if any safety or assistive devices were used for Patient A, she replied, "No". She stated there were no cushioned floor mats, nor an increase of staffing to supervise Patient A.</p> <p>The Care Plan for Patient A were reviewed on October 30, 2008 at 11:30 AM. The Care Plan dated December 12, 2007, read: "RESIDENT</p>		<p>3. Nursing staff will be provided an in-service education regarding anticoagulant medication, risk factors and appropriate physician notification after a fall occurs by DNS or designee. Further inservice education regarding falls and appropriate intervention and communication of resident specific interventions will be provided by DNS and or designee to C.N.A and Licensed Nurses by 3/9/10. Communication to include C.N.A reporting change of conditions to licensed nurses who will document change on 24 hour nursing report to be reviewed by DNS and or designee at morning meeting.</p> <p>The IDT, which includes the DNS and or designee, will review residents who fall to include medication reviews, notifying physicians and updating care plans as indicated.</p>	

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	<p>Continued From page 3</p> <p>FOUND ON FLOOR IN ROOM, INTERVENTIONS", in part read, "ADD BED ALARM TO ALERT STAFF". A second Care Plan dated December 12, 2007 and reviewed on March 17, July 11, June 26, and September 9, 2008 read, "ALTERATION IN ADLs (activities of daily living) IS UNABLE TO PERFORM OWN ADLs, NEEDS ASSISTANCE SECONDARY TO GENERALIZED WEAKNESS AND IMPAIRED MOBILITY", under "INTERVENTIONS", in part it read, "PROVIDE 1 PERSON ASSISTANCE WITH BED MOBILITY. PROVIDE 1-2 PERSON ASSISTANCE WITH TRANSFERS. PROVIDE 1-2 PERSON ASSISTANCE WITH TOILET USE."</p> <p>The Care Plan dated March 4, 2008 read, "RESIDENT FELL. FOUND ON FLOOR STATED SHE WAS SITTING UP AND WAS GOING TO GO TO BATHROOM WHEN FEET HIT FLOOR THEY SKID OUT FROM UNDER HER" under "INTERVENTIONS "in part it read, "PROVIDE SAFETY DEVICE AS NEEDED AND ORDERED BY MD." The Care Plan dated June 19, 2008 read, "MISSED WHEELCHAIR SEAT AND SLID TO FLOOR ON BUTTOCKS", under "INTERVENTIONS", in part it read, "PROVIDE SAFETY DEVICE AS NEEDED AND ORDERED BY MD." The Care Plan dated June 26, 2008 read, "RESIDENT FELL, FOUND ON THE FLOOR", under "INTERVENTIONS" in part it read, "PROVIDE SAFETY DEVICE AS NEEDED AND ORDERED BY MD." The Care Plan dated June 30, 2008 read, "RESIDENT FELL. FOUND ON FLOOR, BESIDE HER BED. WAS ATTEMPTING TO TRANSFER SELF FROM BED TO W/C (wheel chair)", under "INTERVENTIONS", in part it read,</p>		<p>Pharmacy will review residents on anticoagulant drugs on a monthly basis. Recommendations will be communicated to the attending physician by the Licensed Nurse for follow up as indicated.</p> <p>DNS or designee will ensure changes or new interventions are communicated to the Licensed Nuses/CNA's, post meeting and by the licensed nurses during change of shift.</p> <p>4. The ED / DNS will report to the QA&A committee quarterly, for a year any results of the trends of incident reports, corrective action taken and effectiveness of the corrective action. Any further necessary corrections will be implemented immediately.</p>	<p>3.9.10</p> <p>3.9.10</p>

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	<p>Continued From page 4</p> <p>"PROVIDE SAFETY DEVICE AS NEEDED AND ORDERED BY MD." The Care Plan dated October 20, 2008 read, "RESIDENT FELL, FOUND ON FLOOR WITH LACERATION OF LEFT FOREHEAD", under "INTERVENTIONS" in part it read, "PROVIDE SAFETY DEVICE AS NEEDED AND ORDERED BY MD."</p> <p>During an interview and a review of the Care Plan records with the DON on October 30, 2008, at 11 AM when asked what the intervention, "PROVIDE SAFETY DEVICE AS NEEDED AND ORDERED BY MD", meant she stated, "That's just there in case the Dr. orders something.. That's up to him, then it's already in the care plan."</p> <p>During an interview and a review of the Care Plan records with RN (registered nurse) 1 on May 26, 2009 at 11:15 AM, she stated she wrote the Care Plans for Patient A. She explained the intervention, "PROVIDE SAFETY DEVICE AS NEEDED AND ORDERED BY MD", is a generic sentence. She stated she did not know if Patient A had any safety devices used or ordered.</p> <p>During an interview with CNA 2 on May 26, 2009 at 11:10 AM, she stated she remembered Patient A and had taken care of her. She stated Patient A did not have a bed alarm, or any restraints. She further stated Patient A was routinely allowed to transfer herself from bed to wheelchair and from wheelchair to the toilet without assistance.</p> <p>During a review of the clinical record on May 26, 2009 at 11:30 PM, a physician's order dated</p>			

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	<p>Continued From page 5</p> <p>December 20, 2007 read, "Full side rails when in bed due to poor safety awareness." A review of the Documentation Charting Record dated October 19, 2008 indicated side rails were not used on the day, evening, or night shift on October 19, 2008, the night of Patient A's last fall.</p> <p>During an interview with CNA 3 on June 24, 2009, at 10:45 AM, she stated Patient A had a bed with half side rails. We always left them down so she could get in and out of bed to go to the restroom. There was no bed alarm. I would tell her to call for assistance, but she didn't want to. CNA 3 stated one night in June of 2008 she went to check on Patient A and found her on the floor in the restroom. Patient A told CNA 3 she was too weak to get back into her wheelchair and slipped to the floor. CNA 3 stated Patient A was up to the restroom about ten times a night. She was always unsteady on her feet. A review of the Nurse Notes from June indicated that on June 18, 2008 Patient A fell at 10 PM.</p> <p>During an interview with CNA 4 on June 25, 2008 at 1:15 AM, she stated she was working with Patient A on the night of October 19, 2008. CNA 4 went into the room to help because she heard Patient A had fallen and observed Patient A on the floor. CNA 4 stated, "Patient A was up most of the night always going to the restroom to urinate, about every ten minutes or so." When asked if she told the nurse, she stated, "No, everyone knew".</p> <p>During an interview with LN 2 on June 25, 2008 at 1:30 AM, she stated she did not know Patient A</p>				

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	<p>Continued From page 6</p> <p>was up most of the night using the restroom. LN 2 knew she was a high fall risk and always instructed the CNAs to be extra aware of Patient A and her safety. LN 2 stated she did not remember the medications Patient A was taking. She remembered she was on duty the night of October 19, 2008 when Patient A fell and arranged the transfer to the local hospital. She stated there was no extra staffing for supervision of Patient A.</p> <p>A review of the General Acute Care Hospital record of Patient A, dated November 21, 2008 at 2:28 PM, indicated that Patient A was diagnosed with a urinary tract infection on admission into the local hospital on the night of October 19, 2008. A symptom of a urinary tract infection includes frequent urination, which could cause a patient to make frequent bathroom visits during the night.</p> <p>During an interview with Medical Director A of the facility who was also the physician of Patient A, on June 23, 2009 at 9:15 AM, he stated, he was not aware of the events leading up to the death of Patient A. He stated, "What! That is a sentinel event. That's terrible. We should have taken a team approach. We have to address this in a team meeting immediately. I will take care of this today. Patient A should not have been on Coumadin (brand name for the medication Warfarin)". He explained Patient A was on Coumadin to prevent a recurrence of a past DVT (Deep Vein Thrombosis - blood clot in a vein,) and A-Fib (atrial fibrillation, an irregular heart rhythm), but should not have been on it with her current history of falls and not with her diagnosis of dementia. He stated he was unaware</p>			

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	<p>Continued From page 7</p> <p>Patient A was on that medication when the nurses called to inform him she had fallen. He was not involved with a discussion or a team meeting concerning Patient A's plan of care.</p> <p>During a final interview with the DON on May 26, 2009 at 12:30 PM, she stated, "Residents (Patients) have the right to fall."</p> <p>A review of the General Acute Care Hospital record of Patient A dated October 21, 2008, indicated Patient A was transferred to the Emergency Room of the local hospital and admitted on October 20, 2008 after her 6th fall on October 19, 2008 at 10:30 PM. The neurologist MD note dated October 20, 2008 at 10:23 PM, indicated Patient A sustained a C-7 (the seventh neck vertebrae) fracture, a left 1st rib fracture, a large acute left frontoparietal subdural hematoma (a blood clot in the brain caused by excessive bleeding,) and that Patient A was in a coma with a poor prognosis for recovery. The MD Discharge Death Summary note dated November 21, 2008, at 2:28 PM, indicated Patient A died four days after admission on October 24, 2008 from a large intracranial hemorrhage (bleeding into the brain.)</p> <p>This violation presented either an imminent danger to the patient 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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