

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056078</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/27/2007</b>
NAME OF PROVIDER OR SUPPLIER <b>LAKEWOOD MANOR NORTH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>831 S. LAKE STREET, LOS ANGELES, CA 90057 LOS ANGELES 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>Representing the Department of Public Health:</p> <p>CLASS AA CITATION -- PATIENT CARE 97-1269-0005303-F Complaint(s): CA00103271</p> <p>F-157 483.10 (b)(11) Notification of changes A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or and interested family member when there is (A) an accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) a significant change in the resident's physical mental, or psychosocial status (i.e. a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications);(C) a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment,); or</p> <p>F272 483.20 Resident Assessment</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>F309 483.25 Quality of Care Each resident must receive and the facility must</p>			

Event ID:PRQJ11

6/4/2009

2:34:25PM

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	<p><b>Continued From page 1</b></p> <p>provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care.</p> <p>On September 27, 2007, a complaint investigation was conducted at the facility to investigate an allegation involving Resident 1, who was transferred to the acute hospital with a large bruise on his head and shoulder, lethargy, and altered level of consciousness.</p> <p>The resident sustained a right cerebella acute intracranial hemorrhage and expired four days after the accident. According to the resident's death certificate, the immediate cause of death was listed as acute cerebellar hemorrhage and other significant conditions contributing to the resident's death included head trauma.</p> <p>Based on record review and interview, the facility failed to immediately inform and/or consult with the resident's physician, failed to accurately and periodically reassess the resident's head injury, and failed to provide the resident necessary care and services, in accordance with his comprehensive assessment and plan of care by failing to:</p> <p>1. Provide adequate support to Resident 1 for safety during transfer from his bed to the wheelchair, as indicated in his care plan. The resident lost his balance, struck his head on the bed side-rail pole, and sustained a hematoma (swelling containing blood).</p>			

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	<p><b>Continued From page 2</b></p> <p>2. Conduct an accurate assessment that included documentation of the size and color of the resident's head injury in accordance with the Facility's policy and procedure for Falls or Head Injuries.</p> <p>3. Conduct an ongoing assessment of the resident's head injury after the initial assessment and an ongoing assessment of the neurological status of the resident after the accident.</p> <p>4. Consult with Resident 1's attending physician immediately after the resident lost his balance, struck his head on the bed side-rail pole, and sustained a hematoma that required physician intervention.</p> <p>5. Consult with the physician immediately when the resident did not eat lunch, complained of not feeling well, and then refused to eat dinner indicating a significant change for the resident.</p> <p>6. Call 911 in accordance with the Facility's policy regarding emergencies, when the resident was found lethargic and with motor response only.</p> <p>Review of Resident 1's record revealed he was an 83 year-old male, who was admitted to the facility from the acute hospital on August 31, 2006, with diagnoses that included head trauma, brain injury-Sylvian Fissure hyper attenuating bleed and seizure disorder.</p> <p>The MDS (Minimum Data Set) assessment, dated</p>				

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	<p><b>Continued From page 3</b></p> <p>September 7, 2006, indicated he had a short-term memory problem and was moderately impaired with his cognitive skills for daily decision-making. He was totally dependent on the nursing staff for transfers with one-person physical assist for dressing and toilet use. He was assessed to have functional limitation in range of motion in one leg with full loss of voluntary movement. The resident was not able to maintain balance while standing and when he was in a sitting position, used a wheelchair as his primary mode of locomotion.</p> <p>An updated care plan on November 2006, identified the resident as being at risk for falls due to weakness in both lower extremities as manifested by right short leg deformity. The interventions included nursing staff monitoring the resident's environment and providing support for safety when transferring him out of bed to the wheelchair.</p> <p>The renewed Physician's orders for January 2007, indicated to give Aspirin EC (enteric-coated) 81 mg by mouth (PO) daily for ASHD (arteriosclerotic heart disease), originally ordered on August 8, 2006, and Plavix one tablet PO daily for PVD (peripheral vascular disease). According to documentation in the resident's Medication Record, these medications were given at 9 a.m., daily and were administered on January 4, 2009 at 9 a.m. The resident's drug regimen also included dilantin 100 milligrams (mg) three times a day for seizures, terazosin 2 mg at bedtime for hypertension, imdur 30 mg daily for anti-angina, and lexapro 10 mg daily for depression.</p>				

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	<p><b>Continued From page 4</b></p> <p>According to the Nursing Drug 2007 Hand Book 27th Edition, Plavix hinders platelet aggregation, decreases platelet count, which may increase the risk of bleeding, and prolongs bleeding time.</p> <p>The Drug Hand Book indicated that in low doses, Aspirin also appears to impede clotting by preventing the formation of a platelet- aggregating substance. The adverse reactions included prolonged bleeding time and thrombocytopenia (persistent decrease in the number of platelets, that is usually associated with hemorrhagic conditions).</p> <p>A review of the Licensed Nurses Progress Notes, dated January 4, 2007, revealed the following:</p> <p>At 8:00 a.m., the certified nurse assistant (CNA) reported that Resident 1 lost his balance and struck his head on the bed siderail, while they were getting him out of bed. At 8:30 a.m., the resident sustained a hematoma (bruise) on the left side of his head and was assisted up in the wheelchair. The CNA reported the incident to the charge nurse. Vital signs and neuro-checks were done. There was a bluish discoloration on the left side of the head. At 8:45 a.m., on the same date, the attending physician was paged to inform him of the injury. At 10:30 a.m., the resident remained in the wheelchair as staff continued to monitor him. At 12:30 p.m., the resident's attending physician was paged again and the resident remained in the wheelchair. At 2:30 p.m., the resident was assisted to bed after he complained of not feeling well. At 3:30 p.m., the resident was sleeping in bed. The notes indicated, "The resident was noted with a contusion on the left</p>			

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	<p><b>Continued From page 6</b></p> <p>On February 8, 2007 at 3:15 p.m., Employee 2, (CNA) stated the resident lost his balance, fell on his side and struck his head on the bedpost after she and Employee 1 sat him on his bed.</p> <p>On the same day at 4:20 p.m., Employee 4 (LVN) stated that Employees 1 and 2 were not supposed to remove their hands from the resident while getting him up until he was successfully transferred in his wheelchair.</p> <p>On September 27, 2007 at 11:20 a.m., during a second interview regarding the fall incident on January 1, 2007, Employee 1 stated, Resident 1 was unable to sit up by himself and needed two people for transfers from the bed to the wheelchair. She stated that she sat the resident midway at the edge of the bed with the wheelchair positioned in front of the resident. Employee 1 stated as she turned over to lock the wheelchair brakes, the resident passed out, fell on his side and hit the left side of his head on the side rail pole. She also stated the resident was not being held for support while sitting at the edge of the bed and that Employee 2 was standing beside the wheelchair at the time of the incident.</p> <p>In an interview on September 27, 2007 at 3:20 p.m., the Director of Nursing (DON) stated Resident 1 had a problem with his balance while sitting and Employees 1 and 2 were supposed to support the resident with both hands after sitting him in bed to prevent him from falling.</p> <p>A review of the facility's General Guidelines for</p>				

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	<p><b>Continued From page 7</b></p> <p>Resident Safety stipulated the following; Support the resident's body well during positioning, transferring and ambulation; provide two or more persons assist when necessary for resident and staff safety; lock brakes on wheelchairs before transferring residents.</p> <p>The facility staff did not follow its policy for Resident Safety and the plan of care developed for this resident by not providing adequate support for safety when transferring him out of bed to the wheelchair.</p> <p>A review of the facility's policy and procedure for Falls or Head Injuries, indicated that an assessment was to be conducted that includes the size and color of the resident's head injury, evaluating the condition of the resident and documenting in the resident's record, the actions taken.</p> <p>A review of the licensed nurses notes on January 4, 2007, at 8:30 a.m. revealed the resident had a hematoma/bluish discoloration on the left side of his head. However, there was no documentation of an ongoing and comprehensive assessment of the bump or hematoma or bluish discoloration on the left side of the resident's head. There was no assessment of the size and color of the bruise after it was initially assessed at 8:30 a.m., to determine if there was an increase in size, in order to provide the appropriate care based on the comprehensive assessment.</p> <p>On September 26, 2007 at 1:15 p.m., during a</p>				

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DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>056078</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/27/2007</b>
NAME OF PROVIDER OR SUPPLIER <b>LAKWOOD MANOR NORTH</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>831 S. LAKE STREET, LOS ANGELES, CA 90057 LOS ANGELES COUNTY</b>		
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	<p><b>Continued From page 10</b></p> <p>accident.</p> <p>A review of the facility's policy and procedure on Accident/Incidents indicated the charge nurse should notify the victim's personal or attending physician of the accident or incident. The facility's policy on "Notification of Physician" revealed the licensed nurse should call the attending physician if a resident's condition has changed and report the changes and nursing observations. If the attending physician is not available or fails to respond, call the alternate physician, and if the alternate physician is not available, call the Medical Director.</p> <p>Another policy and procedure for Notification of Physicians indicated that if a resident's condition has changed, call the attending physician and report changes and nursing observations. In cases of emergency, call 911.</p> <p>There was no documented evidence on January 4, 2007, that the licensed nurses called either the alternate physician or the Medical Director when Resident 1's attending physician did not respond to the 8:45 a.m., and 12:30 p.m. pages to inform him of the resident's head injury. In addition, the physician was not notified between 12:30 p.m., and 5:30 p.m., when the resident did not eat lunch, complained of not feeling well, and then refused to eat dinner. According to the CNA notes, the resident's meal intake for lunch on the day of the incident was 0%, which was unusual for this resident as his documented food consumption on the Nurse Assistant Care Record for December 2006, and January 1 through 3, 2007 revealed the</p>				

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	<p><b>Continued From page 11</b></p> <p>resident had been eating 80 % to 100% of his lunch and dinner.</p> <p>On January 12, 2007 at 2:30 p.m., during an interview, Employee 3 stated that Employee 1 had reported the resident lost his balance and struck his head on the bedpost. Employee 3 stated she saw the left side of Resident 1's head had swollen soft tissue and she paged the physician but the physician did not respond.</p> <p>In an interview on September 27, 2007 at 3:20 p.m., the Director of Nursing (DON) stated that whenever the attending physician failed to return a call, an alternate physician or the Medical Director should be notified of the resident's change in condition.</p> <p>At 4:00 p.m., on the same date, during a telephone interview, the resident's attending physician stated he did not recall if he received a call on his pager in the morning of January 4, 2007, regarding Resident 1's head injury. The physician said that he normally would respond to his telephone call or pager right away. He also stated that the facility's licensed nurses were to call an alternate doctor or the facility's Medical Director especially if the call was important.</p> <p>The facility staff did not consult with Resident 1's attending physician immediately after the resident lost his balance, struck his head on the bed side-rail pole, and sustained a hematoma that required physician intervention. The facility staff again did not consult with the physician</p>				

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	<p><b>Continued From page 12</b></p> <p>immediately when the resident did not eat lunch, complained of not feeling well, and then refused to eat dinner.</p> <p>A review of the physician's order, dated January 4, 2007 at 8:30 p.m., indicated to transfer the resident to the acute emergency room emergency (ER) for evaluation of left frontal lobe bump and lethargy.</p> <p>A review of the licensed nurses progress notes dated January 4, 2007, revealed that at 9:30 p.m. the resident was transferred to the acute ER via Med Reach Ambulance.</p> <p>Another policy and procedure for Notification of Physicians indicated that in cases of emergency, call 911.</p> <p>The facility did not follow its policy for handling emergencies which required calling 911 for expedient emergency medical care but transferred the resident by an ambulance service that provided only basic life support, one hour after the physician had given a transfer order.</p> <p>A review of the acute hospital ER chart indicated the resident arrived at the acute hospital on January 4, 2007 at 9:58 p.m., and was assessed with altered mental status and lethargy. According to the acute hospital Emergency Department Physician Record, the resident's physical examination revealed the following: Vital signs: temperature - 96.10 F, heart rate - 87, respiratory rate - 22, oxygen saturation - 94% at room air and Blood Pressure- 167/82, GCS = 3-1-4, pupils-2 mm</p>				

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	<p><b>Continued From page 13</b></p> <p>bilateral and non-reactive, eyes deviated down and to the left with a contusion on top of his head.</p> <p>A review of the CT (computerized tomography) of the brain/head performed on January 4, 2007, showed the right cerebella hemisphere hematoma measured approximately 13 x 24 mm (millimeter). The impression indicated right cerebella hemisphere parenchyma hemorrhage, right hemispheric and infratentorial subdural hematoma, small fourth ventricle intaventricular hemorrhage and hydrocephalus.</p> <p>A review of the resident's History and Physical examination from the acute hospital, dated January 5, 2007, revealed the resident was admitted from the facility with altered level of consciousness and lethargy at the nursing home. The resident was verbally non- responsive and had, "Left frontal lobe contusion". The physician's clinical impressions included: Right cerebellar acute intracranial hemorrhage.</p> <p>The acute hospital Progress Record documentation, dated January 5, 2007, revealed the resident was brought to the ER where decreased inspiration was noted requiring intubation. A CT scan of the head revealed a large right cerebella intracranial hemorrhage with subdural hematoma, extension of tentorium in the falcine, probably of traumatic origin. The acute hospital Progress Record, dated January 9, 2007, revealed the resident expired on January9, 2007, at 6.a.m.</p> <p>A review of the Death Certificate revealed the</p>			

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	<p><b>Continued From page 14</b></p> <p>resident's immediate cause of death was acute cerebellar hemorrhage and other significant conditions contributing to the resident's death included head trauma.</p> <p>The facility failed to:</p> <ol style="list-style-type: none"> <li>1. Provide adequate support to Resident 1 for safety during transfer from his bed to the wheelchair, as indicated in his care plan. The resident lost his balance, struck his head on the bed side-rail pole, and sustained a hematoma (swelling containing blood).</li> <li>2. Conduct an assessment that included documentation of the size and color of the resident's head injury.</li> <li>3. Conduct an ongoing assessment of the resident's head injury after the initial assessment and an ongoing assessment of the neurological status of the resident after the accident.</li> <li>4. Consult with Resident 1's attending physician immediately after the resident lost his balance, struck his head on the bed side-rail pole, and sustained a hematoma that required physician intervention.</li> <li>5. Consult with the physician immediately when the resident did not eat lunch, complained of not feeling well, and then refused to eat dinner indicating a significant change for the resident.</li> <li>6. Call 911 in accordance with the Facility's policy</li> </ol>				

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	<p><b>Continued From page 15</b></p> <p>regarding emergencies, when the resident was found lethargic and with motor response only.</p> <p>Failure of the facility staff to immediately notify the physician and to provide the necessary care and services to Resident 1 in accordance with the assessment and plan of care and the facility's policy and procedure for head injury and failure to accurately assess and periodically reassess the resident's head injury presented a substantial probability that serious harm would result, and did result to Resident 1's death.</p> <p>The above violations either jointly, separately, or in any combination presented either an imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result and were a direct proximate cause of Resident 1's death.</p>				

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