

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/22/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER <b>PILGRIM HAVEN HEALTH FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE 373 PINE LANE, LOS ALTOS, CA 94022 SANTA CLARA 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>CLASS AA CITATION -- PATIENT CARE 22-2164-0007186-F Complaint(s): CA00210952</p> <p>Representing the Department of Public Health: [REDACTED], 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>F 323 483.25(h) Free of Accident Hazards/Supervision/Devices 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>This regulation was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to provide adequate supervision and assistance devices to prevent avoidable accidents when:</p> <ol style="list-style-type: none"> <li>The facility failed to monitor the placement of the wanderguard and the walker that was away from Resident A's reach. The walker was in the middle of the room when the resident was found on the floor after a fall.</li> <li>The facility failed to monitor and supervise the resident who had history of falls and</li> </ol>		<p><b>PILGRIM HAVEN PLAN OF CORRECTION F323</b></p> <p>The following plan of correction constitutes Pilgrim Haven's Plan for Compliance in response to the Survey conducted on 12/22/2009.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed because it is required by the provisions of federal and state law.</p> <p>F323</p> <ol style="list-style-type: none"> <li>Resident was discharged to Stanford University Hospital on 12/7/2009 as a DNR.</li> </ol>	

**CALIFORNIA DEPARTMENT OF PUBLIC HEALTH**  
MAY 26 2010  
L & CDMSION  
DAILY CITY

5/27/10  
↓

Event ID: UERE11	5/28/2010	9:26:30AM
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Heanna Snyder</i>	TITLE DON	(X6) DATE 5/26/10

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.

*POC accepted*

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/22/2009
NAME OF PROVIDER OR SUPPLIER  PILGRIM HAVEN HEALTH FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 373 PINE LANE, LOS ALTOS, CA 94022 SANTA CLARA 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 1</p> <p>assessed by the facility staffs as being non-compliant with the use of a walker during transfers and ambulation. The resident had a second fall that resulted to serious head injuries and was the cause of the resident's death after he was transferred to the hospital.</p> <p>3. The facility failed to implement the policy and procedure with revision date of December 2007 for "Assessing Falls and Their Causes" when there was no documented evidence that the licensed staffs assessed possible head injuries that would have been included during neurological checks. There was no Registered Nurse on duty to do accurate and consistent assessment of the resident's decline in condition after the fall on 12/7/09.</p> <p>Resident A was an 85 year old who was admitted to the facility on 7/16/07 with diagnoses that included coronary atherosclerosis of artery bypass graft (surgery creates new routes around narrowed and blocked arteries, allowing sufficient blood flow to deliver oxygen and nutrients to the heart muscle), diabetes mellitus, and essential hypertension. The resident's Minimum Data Set, an assessment tool dated 10/8/09 indicated he had memory problem, independent decision-making ability, needed supervision in walking, needed one-man assist with bed mobility and transfers, fell in the past 30 days, and needed limited assistance in Activities of Daily Living. Resident A had Physician orders including ASA (Aspirin) 81 mg. tablet daily and Plavix (CardioVascular</p>		<p>2. No other residents identified with falls with neurochecks at that time. No residents transferred to hospital following a fall. Current residents reviewed and if a fall occurs neurochecks will be initiated. Residents who are independent with assistive devices are being assessed to ensure device is within reach. Residents with Wanderguards are being assessed to ensure device in place, functioning and monitored by licensed nurses routinely. Director of Nursing and or Nurse Educator is available as a RN and will be contacted with falls.</p> <p>3. In-servicing began at 1320 to licensed nurses on 5/26/2010 reviewing Policy and Procedure "Assessing Falls and Their Causes", reviewing Neuro check sheet which includes assessing for name, time, place, follows</p>	

Event ID: UERE11

5/26/2010

9:26:30AM

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

*Hanna Snyder RD*

TITLE

*DON*

(X6) DATE

*5/26/10*

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:  055210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/22/2009
NAME OF PROVIDER OR SUPPLIER <b>PILGRIM HAVEN HEALTH FACILITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 373 PINE LANE, LOS ALTOS, CA 94022 SANTA CLARA 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><b>Continued From page 2</b></p> <p>drug used to reduce thrombotic events in patients with acute coronary syndrome and coronary artery bypass graft) 75 mg. tablet by mouth daily. There was a Physician order dated 12/2/08 to "check wanderguard daily for functioning - Other - QD (every day).</p> <p>A care plan with an initial date of 12/2/08 and revision date of 5/20/09 indicated, "Use/Application of an external device for prevention of falling. Intervention: low bed." According to the MDS, Resident A needed supervision in walking and one person physical assist with transfers. These assessments were not used to develop a care plan for a resident who was identified by the facility staffs as being at high risk for falls. The use of the wanderguard was not reflected in the care plan.</p> <p>A letter to the Physician on a Fax Transmittal form (No staff's signature) dated 10/3/09 documented, "This is to inform you that the resident above (Resident A) was found sitting on the floor in his room this evening around 7:15 PM. He said he didn't know what he did and he fell with a smile on his face. He sustained a cut on his head (1cm.) in length and an abrasion on his left eyebrow. Called the MD on call and ordered to clean area with NSS (Normal Saline), apply vaseline &amp; cover with steri-strips. Initial treatment done. Denied any pain. VS (Vital signs) are as follows: 120/70, 74, 18, &amp; 92.6. He is already on low bed. But sometimes he doesn't use his walker which is</p>		<p>instructions, slurred speech, vomiting or nausea, complaints pain and dizziness, assess for head trauma such as bruising, sensitivity, raised areas documentation in notes, call DON or nurse educator with falls, reviewed DNR vs hospitalization, reviewed 911 ambulance versus non-emergent ambulance, ensuring assistive devices in reach, Wanderguards in place functioning and checked routinely. In-servicing will continue until charge nurses in-serviced. In-servicing to Certified Nursing assistance began at 1350 reviewing to ensure assistive devices are in place for independent residents. In-servicing will continue until staff in-serviced. If staff on LOA or absent for other reasons staff member will be in-serviced upon return to work. DON or designee will audit 3x/week</p>	

Event ID: UERE11

5/26/2010

9:26:30AM

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

*Mania Snyder*

TITLE

DON

(X6) DATE

5/26/10

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 SERVICE    ENCY  
 DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED  12/22/2009
NAME OF PROVIDER OR SUPPLIER <b>PILGRIM HAVEN HEALTH FACILITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>373 PINE LANE, LOS ALTOS, CA 94022 SANTA CLARA COUNTY</b>		
(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><b>Continued From page 3</b></p> <p>dangerous for him even if told not to. Pls. (please) advise." The Physician responded on 10/5/09 with a written order on the same Fax Transmittal form indicating, "continue current care."</p> <p>On 12/9/09, the facility notified the California Department of Health Services of another incident of a fall. Resident A's Progress Notes by Staff 2 (RN - Day Shift) dated 12/7/09 at 4:21 PM " Fall Note" documented, "CNA (Certified Nurse Assistant) heard somebody yelling for help in the other room. When checked, resident was seen sitting on the floor propped up with his right elbow for support. When asked what happened, resident said he just fell. Resident was seen at the foot part of the bed, walker in the middle of the room. Resident denies hitting his head, claimed that he fell with his bottom first." "ROM (Range of Motion) done on both extremities, able to move without discomfort. Assisted to get up using gait belt. Able to walk using walker without difficulty. Complained of pain in elbow, when checked there was skin tear and bump in the elbow." " MD (Medical Doctor) notified. Steri-strip applied to skin tear and cold compress applied to bump area in elbow. Resident's nephew informed of the incident. Reminded resident to always walk with his walker at all times. Neuro check initiated."</p> <p>During an interview on 1/11/10 at 9:00 AM, Staff 1 (C.N.A float) said, "That day the patient was confused, three times walking without his</p>		<p>times 4 weeks and then random to ensure compliance and also ensuring Wanderguard is in place, monitoring completed, assistive devices are within reach of independent residents unless otherwise care planned. DON or Nurse Educator will audit fall incidents and neuro checks to ensure completed. Post-fall assessments will be completed by IDT monitoring for patterns. Audits will be reviewed at QA for any suggestions/comments.</p> <p>4. Director of Nursing is responsible for sustained compliance and will monitor audits to ensure compliance is maintained per this plan of correction.</p> <p>5. Completion Date June 26, 2010.</p>	

Event ID: UERE11

5/26/2010

9:26:30AM

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

TITLE

(X6) DATE

*Deanna Snyder RD*

*DON*

*5/26/10*

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:  055210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  12/22/2009
NAME OF PROVIDER OR SUPPLIER  PILGRIM HAVEN HEALTH FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 373 PINE LANE, LOS ALTOS, CA 94022 SANTA CLARA 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 4</p> <p>walker. Reminded to use the walker. When the patient fell, the walker was in the middle of the room." Staff 1 said she did not ask if the resident used the walker.</p> <p>Record review of Resident A's Neurological Assessment checklist that was initiated by the licensed nurse on 12/7/09 at 11:15 AM indicated that the resident's vital signs and neurological assessments were within normal range until 7:00 PM. At 9:00 PM, the pupil size was the only assessment documented. At 11 PM, the Neuro Checklist indicated that the resident was coded as "F (Asleep/unable to arouse); hand grip '0' (None)". Temperature was 98.6, Pulse - 96, Respiration - 20, and Blood Pressure was 160/80.</p> <p>Review of the facility's policy and procedure on "Assessing Falls and Their Causes" dated 12/07, "General Guidelines" "...5. Residents must be assessed in a timely manner for potential causes of falls. 6. Relevant environmental issues should be addressed promptly." "Steps in the Procedure 1. After a Fall: a. If a resident has just fallen, or is found on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injuries to the head, neck, spine, and extremities." On 10/29/09 a hand written procedure was added stating, "Neurological signs to be checked and log at least 24 hours." "d. Nursing staff will notify the resident's Attending Physician and family in an appropriate time frame. When a fall results in a</p>			

Event ID: UERE11

5/26/2010

9:26:30AM

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

TITLE

(X6) DATE

*Deanna Snyder RD*

*DO N*

*5/26/10*

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:  055210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/22/2009
NAME OF PROVIDER OR SUPPLIER  PILGRIM HAVEN HEALTH FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 373 PINE LANE, LOS ALTOS, CA 94022 SANTA CLARA 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 5</p> <p>significant injury or condition change, nursing staff will notify the practitioner immediately by phone." "e. Nursing staff will observe for delayed complications of a fall for approximately forty eight (48) hours after an observed or suspected fall, and will document findings in the medical record." "f. Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. It will note the presence of absence of significant findings."</p> <p>The nursing Progress Notes dated 12/7/09 at 11:59 PM documented, " V/S 120/70, 98.6, 70, 20, ambulating in the hallway with walker when received, right after, the activity staff noticed his face (Resident A) turned pale and assisted him to chair. O2 (oxygen) sat (saturation) RA (Right Arm) 97-98%, b/p (blood pressure) 120/70 hr 78, ... assisted back to his room, ate 25% dinner. At 7:30 PM, had an episode of vomiting moderate amount of undigested food. ... resident not responding difficult to arouse, telephone call to nephew regarding advance directive....he wants to talk to the doctor first, wants advice before sending him (Resident A ) to the hospital. Telephone call to nephew informed him that the doctor prefers the resident to the ER (Emergency Room) so all labs can be done immediately." It was documented that the resident's nephew called back saying he wanted the resident to be</p>			

Event ID: UERE11

5/26/2010

9:26:30AM

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

*Deanna Snyder RD*

TITLE

*DN*

(X6) DATE

*5/26/10*

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 SERVICE AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/22/2009
NAME OF PROVIDER OR SUPPLIER  PILGRIM HAVEN HEALTH FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 373 PINE LANE, LOS ALTOS, CA 94022 SANTA CLARA 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><b>Continued From page 6</b></p> <p>transferred to the hospital. The On-call Physician was notified and he gave an order for the resident to be transferred to the hospital.</p> <p>On 12/22/09 at 10:00 AM, Staff 4 (Director of Nursing) was interviewed. Staff 4 said, "It happened 12/7/09 at 11:00 AM. Resident A fell, had a skin tear and slightly swollen elbow. He does not have a steady gait and walks better with a walker. But, sometimes he is non-compliant with the walker. He vomited after dinner and became unresponsive and pale. At 11:30 PM, he was transferred to the hospital and died in the hospital 12/8/09."</p> <p>The medical records did not have a documentation to indicate that the physician was called on 12/7/09 at 7:30 PM when Resident A turned pale and vomited after the fall. The Physician was notified at 9:30 PM when Resident A became unresponsive and his pupils were not reacting to light. Although neurological checks were done every 15 minutes, there was no documented evidence that the licensed nurse assessed the resident for possible head injuries when he started vomiting and became unresponsive. Staff 3 did not notify the Physician right away when the resident started to look pale and started vomiting. The Physician was notified two hours after the resident started getting unresponsive and caused a delay in transferring the resident to the hospital for emergency measures.</p>			

Event ID: UERE11

5/26/2010

9:26:30AM

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

*Heanna Snyder*

TITLE

*DON*

(X6) DATE

*5/26/10*

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:  055210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  12/22/2009
NAME OF PROVIDER OR SUPPLIER PILGRIM HAVEN HEALTH FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 373 PINE LANE, LOS ALTOS, CA 94022 SANTA CLARA 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 7</p> <p>The Physician Discharge Summary dated 12/22/09 documented, "Final Diagnosis-Fall" " Pertinent Physical and Laboratory Findings: LTC (Long Term Care) resident who was stable and fell then became confused. Was sent to hospital ER (Emergency Room) for evaluation." " Follow-up and Discharge Medication Instructions: Expired at the hospital-developed intracranial hemorrhage and family decided comfort care."</p> <p>In an interview on 1/11/10 at 8:35 AM, Staff 2 (Day Shift RN) said, " The resident was walking back and forth sometimes without the walker. He needs to be reminded to use walker. That day the CNA was in the opposite room of the patient. She called and said that the resident was on the floor sitting partly supported by his elbow. Patient said "I fell" and denied hitting his head. The walker was at the foot of the bed. Had history of previous fall in his room. After the fall the physician was notified. No other complains except elbow pain." According to Staff 2, she assessed the resident and got him up from the floor with Staff 1. Staff 2 did neurochecks and the resident's vital signs were "all right". Staff 2 said the room was not cluttered and the floor was dry.</p> <p>In an interview with Staff 3 (LVN - Licensed Vocational Nurse) in charge on 1/14/10 at 2:15 PM., she said, "At 9:30 PM, I went to check the resident's finger stick glucose and noted a lot of mucous on resident's chest. O2 sat is okay but resident was unresponsive. I called the</p>				

Event ID: UERE11

5/26/2010

9:26:30AM

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

*Heanna Snyder*

TITLE

*DON*

(X6) DATE

*5/26/10*

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:  055210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/22/2009
--	--	--	--

NAME OF PROVIDER OR SUPPLIER <b>PILGRIM HAVEN HEALTH FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>373 PINE LANE, LOS ALTOS, CA 94022 SANTA CLARA COUNTY</b>
--	---

(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><b>Continued From page 8</b></p> <p>nephew first. He does not want any aggressive treatment, and then the physician said, ' Tell the nephew that the resident needs labs.' "I was getting uncomfortable with this. I called the MD again, I spent more time talking to the resident's nephew back and forth finally resident's nephew and resident's sister agreed to have resident transferred to the hospital. The resident had a poor appetite during dinner. Around 4:30 PM, the activity staff noticed the resident turned pale we put him to bed. At 7:30 PM the resident vomited and was still responsive until about 9:30 PM I took vital signs and neuro checked but forgot to write it. I was mostly on the phone with the family and MD." When asked how often the neurocheck was done Staff 3 said, "The first hour, we do neuro check every 15 minutes, then 30 minutes x 2, then 1 hour x 4, 2 hours x 4, then 4 hours x 4. When asked how many staff worked for the PM Shift, Staff 3 said, "We do not have an RN Supervisor in the PM Shift. The staff that were on duty on 12/7/09 in the PM Shift were 4 CNAs and one LVN in charge."</p> <p>The facility did not have a Registered Nurse in the PM Shift on 12/7/09 to ensure consistent monitoring and accurate assessment on Resident A's change in condition after the fall in the morning. There was only one licensed nurse (LVN) who spent most of her time calling the Physician and the family who did not want aggressive treatments for the resident. This caused a delay in the resident's transfer to the hospital for emergent treatment and care.</p>			

Event ID: UERE11	5/26/2010	9:26:30AM
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nancy Snyder</i>	TITLE <b>DN</b>	(X6) DATE <b>5/26/10</b>

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 SERVICE AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055210	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED  12/22/2009	
NAME OF PROVIDER OR SUPPLIER <b>PILGRIM HAVEN HEALTH FACILITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 373 PINE LANE, LOS ALTOS, CA 94022 SANTA CLARA 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><b>Continued From page 10</b></p> <p>Record review of Hospital Discharge Summaries dated 12/10/09, Principal Diagnosis at Time of Death: Traumatic Subdural Hematoma. Active Hospital Problems- Traumatic Subdural Hematoma date noted 12/8/09, Herniation of the Brain- date noted 12/8/09.</p> <p>Therefore, the facility failed to provide adequate supervision and assistance devices to prevent avoidable accidents when:</p> <ol style="list-style-type: none"> <li>1. The facility failed to monitor the placement of the walker that was away from Resident A's reach, and failed to monitor the application of the bed alarm/wanderguard. The walker was in the middle of the room when the resident was found on the floor after a fall.</li> <li>2. The facility failed to monitor and supervise the resident who had history of falls and assessed by the facility staffs as being non-compliant with the use of a walker during transfers and ambulation. The resident had a second fall that resulted to serious head injuries and was the cause of the resident's death after he was transferred to the hospital.</li> <li>3. The facility failed to implement the policy and procedure with revision date of December 2007 for "Assessing Falls and Their Causes" when there was no documented evidence that the licensed staffs assessed possible head injuries that would have been included during neurological checks. There was no RN on duty to do accurate and consistent assessment of the resident's decline in condition after the fall on 12/7/09.</li> </ol>			

Event ID: UERE11

5/26/2010

9:26:30AM

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

TITLE

(X6) DATE

*Heanna Snyder*

*DN*

*5/26/10*

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:  055210	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED  12/22/2009	
NAME OF PROVIDER OR SUPPLIER PILGRIM HAVEN HEALTH FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 373 PINE LANE, LOS ALTOS, CA 94022 SANTA CLARA 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><b>Continued From page 11</b></p> <p>The above violations presented an imminent danger to the patient, and was a direct proximate cause of the death of the patient.</p>			

Event ID: UERE11

5/26/2010

9:26:30AM

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

TITLE

(X6) DATE

*Alanna Snyder RD*

*DON*

*5/26/10*

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.