

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055045	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/12/2009
NAME OF PROVIDER OR SUPPLIER RIVIERA HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8203 TELEGRAPH RD, PICO RIVERA, CA 90660 LOS ANGELES COUNTY		
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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 94-1645-0005817-S Complaint(s): CA00173598</p> <p>72311. Nursing Service-General</p> <p>(a) Nursing service shall include, but not be limited to, the following:</p> <p>(1) Planning of patient care, which shall include at least the following:</p> <p>(A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission.</p> <p>(B) Development of an individual, written patient care plan which indicates the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited.</p> <p>72523. Patient Care Policies and Procedures</p> <p>(a) Written patient care policies and procedures shall be established and implemented to ensure</p>			

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	<p>Continued From page 1</p> <p>that patient related goals and facility objectives are achieved.</p> <p>Based on observations, interviews and record reviews, the facility failed to assess and follow its policy and procedures in assessing and developing an individualized plan of care for risk factors in smoking for Patient 1. Patient 1, who was non-ambulatory with right-sided weakness, range of motion limitations and poor fine motor skills had been allowed to smoke in the facility for over six weeks without a plan of care to provide a safe environment, preventing injury and harm. The patient set himself on fire while attempting to light his cigarette, while in the facility's dining room unsupervised. While Patient 1 was on fire the facility's staff initially panicked before the fire was put out, although there was a fire blanket and a fire extinguisher approximately six feet away from the patient. Patient 1 sustained second and third degree full thickness burns over approximately 40% of his body. He was transferred to two acute hospitals, underwent skin graft surgery, had kidney failure requiring dialysis was admitted to intensive care with mechanical ventilation (life support), multiple blood transfusions, and required morphine sulfate intravenous for pain management before expiring 18 days after the incident. The facility failed to respond immediately and appropriately in accordance with the facility's fire policy and procedure, while the patient was on fire.</p> <p>According to Patient 1's death certificate his death was caused by multi-system organ failure and</p>			

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	<p>Continued From page 2</p> <p>sepsis (blood infection). The Coroner's report dated January 14, 2009, indicated, "Patient 1's cause of death is thermal burns and sequelae (including sepsis and multi-organ failure.)"</p> <p>The facility sent an unusual occurrence report to the Department of Public Health indicating that on December 23, 2008 at 8:30 p.m., staff found Patient 1 lying on the floor in front of his wheelchair with his pants on fire. According to the report, Patient 1 sustained burns on his legs, thighs and groin area and was transferred to the nearest acute facility.</p> <p>On January 9, 2009 at 10:25 a.m., an unannounced investigation was conducted. During an interview, Employee E stated Patient 1 was found in the back dining room on the floor on fire. Employee F entered the room during the interview, and stated Patient 1 did smoke and was seen asking visitors for cigarettes and matches earlier that same day.</p> <p>A review of Patient 1's closed clinical record (face sheet) indicated he was admitted to the facility on December 27, 2005. His current diagnoses included cerebral vascular accident (CVA) with right hemiparesis (one side paralysis), dysphagia (difficulty swallowing), diabetes mellitus with ophthalmic manifestations (impaired vision), and hypertension.</p> <p>A review of a Minimum Data Set (MDS) dated March 16, 2008, indicated Patient 1 was a 64 year-old male, who usually could make his needs known, but had difficulty finding words, finishing</p>				

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	<p>Continued From page 3</p> <p>thoughts, and required frequent cueing and re-orientation from staff. In addition, the MDS indicates under section I that Patient 1 had diabetic retinopathy. There was no documentation in the patient clinical record that Patient 1 was a smoker or a plan of care to address his smoking, although some of the facility's staff were aware that he smoked and had a history of asking visitors for cigarettes and matches.</p> <p>On January 9, 2009, a review of the patient's clinical record revealed that it contained 24 different care plans (1). Although some staff members at the facility were aware of Patient 1's smoking activities, 22 of the 24 care plans failed to identify the patient as a smoker, or provide any plan to supervise his smoking activity. The two care plans that did identify Patient 1 as a smoker were initiated on December 23, 2008, after the fire incident(2).</p> <p>On January 9, 2009 at 11:35 a.m., during an interview, Patient 2 stated she and Patient 1 were watching television in the dining room unsupervised. She stated she saw Patient 1 pull a cigarette out of his pocket and later she looked over towards Patient 1 and he was in flames. Patient 2 stated she started screaming and Employee D came into the dining room to help Patient 1 because he was still on fire. Patient 2 stated the fire went out when the nurse (Employee A) put something over Patient 1. Patient 2 stated she had seen Patient 1 smoking out on the patio a few days before the fire.</p> <p>A review of Patient 2's clinical record indicated she was admitted to the facility on May 13, 2007, with</p>			
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	<p>Continued From page 4</p> <p>diagnoses that include cerebral vascular accident with right-sided weakness. A review of the MDS dated September 3, 2008, indicated Patient 2 was alert and oriented, with memory intact.</p> <p>At 2:45 p.m., during an interview, Employee C stated Patient 1 was alert with periods of forgetfulness, poor with names but able to recognize faces. Employee C stated Patient 1 had poor fine motor skills, limitation and weakness on one side (right) requiring assistance with grooming, activities of daily living, and needed supervision during meal times.</p> <p>On January 9, 2009, during a review of Patient 1's acute clinical record (first hospital) the Emergency Medical Services (EMS) Report indicated Patient 1 was lying on the floor after his clothes were lit with cigarettes/matches sustaining second and third degree burns to both legs, genital, right hand and "bottom area", approximately 40 % of his body was burned. The paramedics transferred Patient 1 to the nearest hospital where he was placed on an intravenous morphine drip and stabilized in guarded condition and then transferred to the second acute hospital (burn unit) on December 24, 2008 at 12:18 a.m.</p> <p>During a telephone interview on January 9, 2009 at 3:45 p.m., Employee D stated that on the date of the incident with Patient 1, she heard a loud noise and went to see where it came from and saw Patient 1 on fire in the dining room. She stated other staff was in the dining room and she left to get a fire extinguisher, but upon her return Patient 1</p>			

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	<p>Continued From page 5</p> <p>was no longer on fire. Employee D stated Patient 1's pants were burned completely away with burnt flesh visible.</p> <p>On January 9, 2009 at 3:50 p.m., during a telephone interview, Employee A, Patient 1's primary evening-shift care provider, stated Patient 1 started smoking cigarettes outside on the patio about a month before the fire. Employee A stated Employee B was the first person to find Patient 1 on fire. Employee A stated Employee B was already in the dining room screaming loudly for help and then ran out. Employee A stated she entered the dining room with two other employees, and saw Patient 1 in flames on the floor. She stated she rolled Patient 1 across the room to smother the flames. She stated another employee came and poured water over Patient 1.</p> <p>On January 9, 2009 at 4:15 p.m., during a telephone interview, Patient 1's family member stated that Patient 1 had smoked years ago prior to having the stroke. Patient 1's family member stated the facility never informed her that Patient 1 had been smoking. When asked how Patient 1 was doing, she stated he had third degree burns on his legs and thighs and had a recent skin graft surgery that did not take. She stated Patient 1 was not doing well, and the doctor gave him only a 20 percent chance of survival.</p> <p>At 4:25p.m., during a telephone interview, Employee G, the registered nurse (RN) supervisor stated she was in the medication room during the time of the fire incident and heard screaming. She</p>			
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	<p>Continued From page 6</p> <p>stated employees were running towards her and away from the fire, instead of assisting Patient 1. Employee G stated Patient 1 was no longer on fire by the time she reached the dining room, but she placed a wet bath blanket on and in between his legs. She also stated the unlit cigarette was found on the floor torn in half and she asked the patient where did he get the matches and he told her, "From a girl" Employee G stated the dining room was filled with smoke just enough to make you cough, but the smoke alarm did not go off. Employee G also stated Patient 1 had a former roommate, who was a smoker, and following the roommate's discharge from the facility, Patient 1 had been observed by staff looking in the ashtrays for cigarettes.</p> <p>On January 12, 2009 at 1:35 p.m., during an interview, Employee C stated a smoking history was assessed on each patient. She stated smoking materials are kept locked up by the charge nurses. Employee C stated the patient must be alert and oriented to be allowed to smoke and all staff was made aware once a patient was identified as a smoker. However, there was no evidence by the facility in Patient 1's closed clinical record indicating or indicated that he was assessed for smoking.</p> <p>According to the facility's policy and procedure titled Smoking dated March 31, 2008, indicated the facility would assess a patient for safe smoking practices and develop a plan of care. Several of the facility's staff were aware of Patient 1's desire to smoke and smoking practices, however the facility</p>			
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	<p>Continued From page 7</p> <p>failed to assess and develop an individualized plan for the patient to smoke and safely use smoking materials; no such assessment was reflected in Patient 1's care plan. In addition, the facility failed to make periodic checks to determine if Patient 1 had any smoking articles as mandated by the facility's smoking policy and procedure. The facility failed to implement its "Resident Assessment for Smoking" sheet, as mandated by the facility's policy and procedure, therefore Patient 1's comprehension, behavior, and physical ability to smoke were not assessed.</p> <p>At 1:44 p.m., during an interview and testing of smoke detectors, Employee H stated he initially had concerns about why the smoke detector did not alarm during the fire, but he stated the staff informed him the smoke did not rise up to the smoke detector. Employee H stated he did not know that Patient 1 smoked, but had seen him in the patio two weeks prior looking in the ashtray for cigarettes.</p> <p>On January 12, 2009 at 2 p.m., during an observation of the dining room where Patient 1 was on fire, a fire blanket and a fire extinguisher were observed approximately six feet away from where Patient 1 was on fire. At 2:15 p.m., Employee I (staff developer) stated the facility's policy for fire was "RACE" which means rescue, pull alarm, contain fire, call 911 and evacuate and extinguish the fire. Employee I stated the staff should had removed Patient 2 from the area during the fire and they should have used the fire blanket.</p>			

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	<p>Continued From page 8</p> <p>A review of the facility's undated policy and procedure titled Fire Procedures, indicated that when a fire is discovered the staff should remove the resident, confine the fire by closing doors and windows, activate the nearest fire alarm box, and call the switchboard and/or fire department.</p> <p>On January 12, 2009 at 3:35 p.m., during an interview, Employee B stated (via translator) she heard another patient yelling for approximately two minutes outside the dining room door where Patient 1 was on fire. She went in the dining room and saw Patient 1 on the floor in flames. She stated Patient 2 was approximately eight feet away from Patient 1 while he was on fire. When she was questioned about the fire blanket she stated she did not know where the fire blanket was and she was not allowed to use a fire extinguisher on patients.</p> <p>At 3:44 p.m., during another interview, Employee G (RN Supervisor) stated she did not sound the fire alarm, but did call 911. She stated she did not use the fire blanket because she did not know how it worked.</p> <p>On January 13, 2009 at 10:30 a.m., a review of the second acute hospital's closed records for Patient 1 indicated he expired on January 10, 2009. The records indicated Patient 1 was admitted on December 24, 2008. According to the Physician's Discharge Summary dated January 10, 2009, Patient 1 suffered partial and full thickness burns to his bilateral lower extremities and abdomen. On December 30, 2008, Patient 1 underwent a skin graft surgery to the lower extremities with primary</p>				

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(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>(1) Care Plans: Risk for adverse reaction to flu shot; Alteration nutrition/hydration; Needs physical restraint; High risk for falls; High risk for falls; Risk for fall/ injury; Risk for social isolation: Depression; Requires assist with ADL's; Actual fall; Adjustment to facility environment; High risk for skin breakdown; Altered mental status; Risk for dehydration; Risk for electrolyte imbalance; Risk for bruising and bleeding; Risk for cardiac complication; Risk for GI distress; Risk for hypo/hyperglycemia; Risk for constipation; Weight management; Requires assistance with mobility; Activity; Memory recall deficit.</p> <p>(2) Resident is a smoker, Burn.</p>			

Event ID:710Q11

4/13/2009

3:18:56PM

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.