

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055884	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2009
NAME OF PROVIDER OR SUPPLIER SAN TOMAS CONVALESCENT HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 3580 PAYNE AVENUE, SAN JOSE, CA 95117 SANTA CLARA 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: [REDACTED], HFEN</p> <p>CLASS AA CITATION -- PATIENT CARE 07-2098-0006439-F Complaint(s): CA00193421</p> <p>F323 - 483.25(h) Accidents and Supervision 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>The facility failed to ensure the environment remained as free from accident hazards as possible and the resident received adequate supervision for one of one sampled resident (1) with an unsteady gait when the facility failed to update and implement a care plan regarding fall prevention. Resident 1's fall prevention care plan approaches included monitoring at all times and the use of a personal alarm. However, a personal alarm was not in use at the time of her last fall. A physical therapy recommendation dated 3/25/09 for Resident 1 to have assistance at all times while walking was not included in Resident 1's care plan. On 4/3/09, Resident 1 sustained her seventh fall while walking unobserved in her room. Resident 1 sustained fractures of her facial bones, and the orbit of her left eye, and a subdural hematoma (bleeding within the brain). On 4/16/09 Resident 1 expired. The death certificate indicated the</p>			

Event ID:441R11

8/18/2009

8:40:01PM

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

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	<p>Continued From page 1</p> <p>immediate cause of death was from blunt trauma to the head.</p> <p>Resident 1 was an 83-year-old female admitted to the facility on 3/3/09 with diagnoses including Alzheimer's dementia with agitation, history of frequent falls, restless leg syndrome and major depression. During closed record review on 7/1/09, Resident 1's admission Minimum Data Set (MDS), an assessment tool dated 3/16/09 indicated the resident had modified independence with some difficulty in decision-making in new tasks or situations and had short and long-term memory problems. The MDS also noted the resident had an unsteady gait, needed supervision and set-up help for walking, and needed limited and one person physical assistance in transferring, e.g., getting out of bed to a standing position.</p> <p>During an interview on 7/1/09 at 3:35 p.m., certified nurses assistant A (CNA A) stated he was assigned to care for Resident 1 on the evening shift of 4/3/09. CNA A stated Resident 1 was very confused, anxious, and had difficulty sleeping. He stated Resident 1 walked independently in the hallways and in her room using a walker (a four legged device use to provide steadiness while walking) and also used a wheelchair. He stated Resident 1 was noted to walk at times with her eyes closed. He stated due to Resident 1's anxiety and restlessness, staff visited or helped Resident 1 "about every 5 minutes." He stated at approximately 8:00 p.m. he put Resident 1 to bed and then went to an adjoining room to care for another resident. He stated he left a wheelchair</p>				

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	<p>Continued From page 2</p> <p>parked at the head of Resident 1's bed and a walker situated near the foot of the bed. He stated about three minutes after leaving Resident 1 he heard a loud crash, returned to Resident 1's room, and saw the resident lying in approximately the center of the room on her back. A dresser was lying across her lower body and a flat-screen television about 3 feet long and 3 feet wide lying on top of her head and chest. He stated the television was attached to the dresser with straps. He stated a corner of the television had injured Resident 1's head and there was bleeding from the back of her head. He stated Resident 1's walker was situated immediately adjacent to her body. CNA A stated he assisted other staff in removing the dresser and the television from on top of Resident 1 and noted it was difficult to do so. CNA A stated paramedics were summoned and Resident 1 was transferred to an acute care hospital. He stated regarding the fall he thought Resident 1 got out of bed and then using the walker approached the dresser and television. He stated for unknown reasons Resident 1 tried to remove the television from atop the dresser. The television was strapped down to the dresser, so possibly Resident 1 pulled the television and the dresser down on herself.</p> <p>On 7/1/09 at 3:50 p.m. during observation of the room in which Resident 1 had resided, CNA A pointed to a dresser and stated it was the same one that fell on Resident 1. It was 30 inches tall, about 18 inches deep, and contained three drawers. On the top of the dresser were four small holes in a rectangular pattern corresponding to where securing straps may have been previously</p>				

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	<p>Continued From page 5</p> <p>personal alarm was tried. There was no evidence any other measure was implemented to ensure Resident 1's safety. The DON stated the care plan approach dated 3/28/09 to monitor at all times meant staff was to supervise Resident 1 at all times. The DON stated she did not know why the care plan had decreased supervision to monitor every two hours on 3/31/09 given that the resident had fallen again. The DON examined the record and stated there was no documentation Resident 1 was monitored at all times. She stated, "It did not happen." The DON stated constant supervision is not normally provided by the facility, and family members may elect to provide a caregiver to stay with a resident at all times at their cost. However, the DON stated if constant supervision was deemed necessary to ensure a resident's safety, then the facility would provide a caregiver to stay with that resident at all times. When asked why constant supervision was not provided for Resident 1, the DON stated caregivers were checking on Resident 1 frequently during the day, and at night, the DON stated she had instructed nurses assistants to sit on a chair near Resident 1's room to keep her under surveillance. The DON checked the record and stated there was no documentation the night surveillance was implemented.</p> <p>During an interview and record review on 7/2/09 at 11:55 a.m., licensed physical therapist A (LPT A) described the resident as anxious and staff needed to be present because Resident 1 became short of breath and her oxygen saturation (a measurement of how much oxygen is in the bloodstream) would drop. He stated toward the end of her stay</p>				

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	<p>Continued From page 6</p> <p>Resident 1 was at higher fall risk because she was drowsy and tired and needed a standby wheelchair when walking to rest on. Review of the physical therapy (PT) evaluation dated 3/4/09 documented when walking with a front wheel walker, the resident needed minimum assistance. Review of the PT discharge note on 3/25/09 recommended Resident 1 required minimum assistance from staff members when she walked. LPT A stated minimum assistance meant physical contact was needed when Resident 1 walked. LPT A stated he gave verbal discharge physical therapy instructions to nursing staff.</p> <p>A review on 7/2/09 of the undated Restorative Nursing Assistant (RNA) Program Policy directed PT/RNA to establish RNA programs when residents were discharged from rehabilitation services. It stated appropriate documentation was to be maintained in the medical record. Review of the medical record indicated there was no documentation the resident's functional status (ability to perform daily tasks such as walking) assessed by rehabilitation staff upon discharge was updated in the impaired physical functioning care plan dated 3/3/09. Also, there was no documentation discharge PT instructions were given to the RNA staff. In an interview on 7/2/09 at 9:00 a.m., the DON stated rehabilitation discharge instructions to nursing staff were to be completed on the RNA form but she could not locate the written instructions.</p> <p>A review on 7/2/09 of Resident 1's "Care Plan on ADL's" (Activities of Daily Living) dated 3/3/09</p>				

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	<p>Continued From page 8</p> <p>feeding tube was placed in her stomach. However, she developed a severe infection in her colon and subsequently died within a few days.</p> <p>On 7/14/09 a review of the resident's death certificate issued on 4/24/09 stated the immediate cause of death was from blunt trauma of the head with skull fractures and subdural hematoma (bleeding).</p> <p>The facility failed to provide adequate supervision and update Resident 1's care plan to include her need for minimal physical assistance when walking, and failed to implement care plan interventions to monitor her at all times and the use of a personal alarm. Resident 1 fell while walking unassisted in her room on 4/3/09. Resident 1 was found on the floor in her room with a television set and dresser on top of her. Resident 1 sustained a fracture of her facial bones and a subdural hematoma. Resident 1 expired on 4/16/09.</p> <p>The above violations 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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