DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555400	A. BUILDING _____ B. WING _____	C 08/09/2023

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NORWOOD PINES ALZHEIMERS CENTER	500 JESSIE AVENUE SACRAMENTO, CA 95838

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of complaint #CA00850727. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 43247 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	F 000	**F000** The filing of this plan of correction does not constitute an admission that the deficiencies allegedly did, in fact, exist. This plan of correction is filed as evidence of the facility's efforts to comply with the requirements of participation and to continue to provide quality resident care.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe environment when one of three sampled residents (Resident 1) did not have adequate supervision and had two falls in three months. This failure resulted in Resident 1 experiencing head injuries that possibly caused a subdural hematoma [a pool of blood between the brain and its outermost covering] necessitating a hospital stay. Findings:	F 689	**F689** **HOW CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** **Inservice done on 8/29/23 by DON in regard to importance of 1:1 supervision in the roo. Staff were advised to call for assistance when they are assisting other residnets in that room. LIC nurses were inserviced on 8/29/23 by DON ,the importance of supervision and to assist the CNAs in the room when called for supervision.** **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTEDBY THE SAME DEFIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN:** **Line of sight supervision for fall risk residents. Referred to Therapy,pharmacy and MD for further evaluation.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 9/14/23

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. (See instructions.) Except for nursing homes, the findings stated 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.

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F 689	Continued From page 1	F 689		

A review of Resident 1's "Admission Record" indicated Resident 1 was admitted to the facility in December 2022 with multiple diagnoses including Alzheimer's disease (disease that destroys memory and other mental functions), chronic kidney disease (loss of function of the kidneys, do not filter the blood the way they should), and diabetes (too much sugar in the blood).

A review of Resident 1's Minimum Data Set (MDS- an assessment tool), Cognitive Patterns, dated 6/26/23, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 0 out of 15 that indicated he was severely cognitively impaired. A review of Resident 1's MDS, Functional Status, dated 6/26/23, indicated Resident 1 required supervision for transfers and walking and did not use any mobility device.

A review of Resident 1's "Fall Risk Observation/Assessment," dated 12/23/22, indicated Resident 1 had a fall risk score of 10 that indicated he was at moderate risk for falls.

A review of Resident 1's "Fall Risk Observation/Assessment," dated 3/24/23, indicated Resident 1 had a fall risk score of 20 that indicated he was at high risk for falls.

A review of Resident 1's "Fall Risk Observation/Assessment," dated 6/16/23, indicated Resident 1 had 1-2 falls in the last 90 days and had a fall risk score of 24 that indicated he was high risk for falls.

A review of Resident 1's "SBAR [situation-background-assessment-recommendati

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F 689	Continued From page 2 on] Communication Form," dated 4/27/23, indicated, "...RESIDENT HAD UNWITNESSED FALL IN BATHROOM, SLIPPED ON A WET SPOT, LANDED ON FACE, SUSTAINED LACERATION TO RIGHT EYEBROW SIZE 2.5 CM [centimeters] APPROAX [SIC] A SCANT BLEEDING, WHICH HAS STOPPED, STERISTRIPS [adhesive strips used to close wounds] APPLIED. PAIN MEDICATION IS GIVEN FOR DISCOMFORT AND IS EFFECTIVE. NEURO [neurological] CHECK IS INITIATED AND IS AS PER BASELINE. MD [medical doctor] NOTIFIED, RP [responsible party] TO BE NOTIFIED BY AM NURSE. RESIDENT IS NOT IN ACUTE DISTRESS AT THIS TIME..." A review of Resident 1's "SBAR Communication Form," dated 5/31/23, indicated "...Resident resting eyes closed responds slowly to tactile stimuli, Apical [pulse over heart]102. CNA [certified nursing assistant] reported resident sleeping all day and was incontinent. Skin warm and dry. Non responsive to verbal stimuli. Blood sugar reading Hi [high] second reading 576. RP notified/ [name of MD] notified...sent to ER [emergency room] ..." A review of Resident 1's "SBAR Communication Form," dated 7/22/23, indicated "...WHILE PROVIDING CARE FOR RESIDENT'S ROOMMATE, CNA HEARD THUMP SOUND, WHEN TURNED, SAW RESIDENT GETTING UP FROM FLOOR. HE WAS POINTING OUT AT THE BACK OF HEAD. QUICKLY GOT UP FROM THE FLOOR AND WAS GETTING OUT OF ROOM. CNA IS NEXT TO HIM TO ASSURE HIS WELLFARE [SIC], WHEN CN [charge nurse] (THIS WRITER) WAS PASSING BY, THE NEWS	F 689		

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F 689	Continued From page 3 WAS BROUGHT IT UP EARLIER, RESIDENT WAS UNABLE TO RELAX, PLAYING WITH HIS LINENS, REFUSED TO GO/STAY IN BED...PLAN ER VISIT..." A review of Resident 1's "Progress Note," dated 4/27/23, "...Resident had unwitnessed fall with injury 04/27/23@ 3:30 am with laceration to right eyebrow, discoloration to left eye. He was found in prone in the bathroom...Risk factors...unsteady gait...Ensure that resident is supervised when he goes to the bathroom...Resident slipped on the wet surface in his bathroom, causing him to fall..." A review of Resident 1's "Progress Note," dated 5/31/23 at 22:01 [10:01 p.m.], indicated "... [name of hospital] ER called for updated report resident admitted with ALOC [altered level of consciousness] abnormal CT [computerized tomography] scan subdural hematoma...." A review of Resident 1's Progress Note, dated 6/1/23, indicated "...Called [name of hospital] as per the nurse the resident is diagnosed with subdural hematoma and resident is shifted to ICU [intensive care unit] ..." A review of Resident 1's "Progress Note," dated 7/23/23, indicated "...res [resident] arrive back from er s/p [status post] fall with injury. he has stitches to the back of his head..." A review of Resident 1's "Progress Note," dated 7/24/23, indicated "...Resident had an unwitnessed fall, per CNA was found on the floor with laceration on the head measuring 2.5 cm while CNA was providing care to another resident in the room on 07/22/23 @ 2245 pm [10:45 p.m.] .... sent out to [name of hospital], returned back	F 689		

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F 689	Continued From page 4 with staples to the laceration..." A review of Resident 1's Care Plan "Unwitnessed fall with head injury," initiated 7/22/23, indicated "Interventions/Tasks...Notify MD/RP/DON [Director of Nursing], Assess for injury, pain, neuro check; transfer to ER for eval and treatment...notify MD/RP if changes occur..." A review of Resident 1's Care Plan "Resident at risk for falls r/t [related to] Dementia, unstudy [sic] gate [sic]," initiated 7/24/23, indicated "Interventions/Tasks...Anticipate and meet...needs...Encourage to use assistive devices...Monitor risk factors for falls...Resident needs, needs a safe environment..." A review of Resident 1's CT scan of the head report, dated 4/19/23, done at an acute hospital after a fall during an elopement on 4/19/23, indicated "...Findings: ...There is no evidence of acute hemorrhage [bleeding]..." A review of Resident 1's hospital critical care progress note dated 6/1/23, indicated: "...CT Brain wo [without] contrast...6/1/2023...Impression:...acute on chronic subdural hematoma along the right cerebral convexity [surface of the brain] maximum thickness of approximately 1.3 cm [centimeter] as before. There again is small amount of blood...consistent with additional small acute subdural... CT Brain wo contrast..5/31/23...Impression: ...Acute on chronic right subdural hematoma without midline shift [displacement of the brain] ...Dense interhemispheric fissure [groove	F 689		

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F 689	Continued From page 5 separating the cerebral hemispheres of the brain] indicating interhemispheric subdural hemorrhage...Petechial hemorrhage [areas of bleeding] in the basal ganglia [brain structures responsible for motor control] ..." A review of Resident 1's CT scan wo contrast of the brain, dated 7/23/23, indicated "...No acute hemorrhage, large vessel territory infarction [obstruction of the blood supply] or mass. Chronic right...subdural hematoma measuring 6-7 mm [millimeters] in maximal thickness..." A review of Resident 1's "Hospitalist Discharge Summary," for acute hospital stay 6/7/23 to 6/9/23, indicated "...CT brain wo contrast: 6/7/2023 Impression: Unchanged acute on chronic right-sided subdural hematoma. Unchanged minor midline shift..." A review of Resident 1's "Hospitalist Discharge Summary," for stay 5/31/23 to 6/4/23, indicated "...Final Diagnosis: ...Subdural hematoma...Admitted on 5/31/2023 with altered mental status due to a SDH [subdural hematoma] ... Acute on chronic right subdural hematoma...Petechial bilateral basal ganglia hemorrhage... admitted to neuro ICU for monitoring..." During a telephone interview on 7/25/23 at 12:55 p.m. with Resident 1's RP, the RP stated Resident 1 climbed over the fence at the facility and fell. He was monitored for 24 hours was told he was "fine." The RP stated the same week in April 2023 Resident 1 fell off the toilet in the bathroom. The RP stated one to two months later, Resident 1 was quiet and seemed to not be feeling well. The RP stated she told the	F 689		

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F 689	Continued From page 6	F 689		

supervisor to send him to the emergency room. The RP stated he had a brain bleed from a fall. Resident 1 also fell off the bed on Sunday (7/22/23), was taken to the emergency room and had stitches in the back of his head. The RP stated, "Feel like they could have done more to prevent his falls."

During an interview on 7/26/23 at 11:10 a.m. with the Assistant Director of Nursing (ADON), the ADON stated Resident 1 has had a couple of falls. The ADON stated Resident 1 fell in the bathroom on 4/27/23, had a laceration of the face, but was not sent to the hospital. The ADON stated Resident 1 fell in his room on 7/22/23 while the CNA was changing another resident, was sent to the hospital, and required four staples to the back of his head. The ADON stated that Resident 1 was moved to the behavior monitoring room after 4/19/23 elopement episode. The room has six residents with one CNA in the room at all times. The ADON stated Resident 1 was sent to the hospital on 5/31/23 for increased lethargy and suspected hyperglycemia. Resident 1 returned from the hospital with new diagnosis of subdural hematoma.

During an interview on 7/26/23 at 12:33 p.m. with the MD, the MD stated Resident 1 has small chronic subdural hematoma and has had so many falls that cannot correlate which fall caused it. The MD stated, "The subdural hematoma is very small, no treatment needed, but unable to determine when it occurred."

During an observation on 7/26/23 at 12:36 p.m. of Resident 1, Resident 1 was sleeping and did not arouse to voice. Resident 1 was in a low bed and did not have fall mat at bedside. One CNA was in

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F 689	Continued From page 7 the room with four other sleeping residents. During an interview on 7/26/23 at 12:38 p.m. with CNA 1 in Resident 1's room, CNA 1 stated she cannot control Resident 1 sometimes. CNA 1 stated falls sometimes happen when she is helping another resident in the bathroom and cannot take care of everyone at the same time. CNA 1 stated, "Need another person, cannot work with all patients at the same time." During an interview on 7/26/23 at 12:41 p.m. with Licensed Nurse (LN) 1, LN 1 stated Resident 1 is ambulatory with a slow gait, is hard to redirect, and not aware of his own safety. LN 1 stated Resident 1 had a recent fall on the pm shift. Resident 1 is hard to keep from falling and will try to elope. LN 1 stated she stays near the behavior monitoring rooms to help CNAs if need help. LN 1 stated, "Don't have two CNAs assigned to each room, that would be ideal." During an interview and record review on 7/26/23 at 1:20 p.m. with the ADON, reviewed Resident 1's Care Plans "Unwitnessed fall with head injury," initiated 7/22/23, and "Resident at risk for falls r/t Dementia, unstudy [sic] gate [sic]," initiated 7/24/23. When asked if there was a care plan for Resident 1 for fall risk prior to 7/22/23, or for previous fall on 4/27/23, the ADON stated, "Not able to find one. Should have had a care plan." When asked what the risk to Resident 1 is if there is not a current care plan, the ADON stated, "Nurses don't know what interventions should be used such as keeping items within reach or using a low bed." During a telephone interview on 7/27/23 at 11:09 a.m. with the Director of Nursing (DON), the DON	F 689		

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F 689	Continued From page 8 stated Resident 1 has fallen two times, on 4/27/23 and 7/22/23, since elopement on 4/19/23 and both falls occurred during night hours. The DON stated that the room may have been dark or dim and Resident 1 had an unsteady gait. The DON stated Resident 1 was sent to the hospital on 5/31/23 for hyperglycemia and returned with a diagnosis of subdural hematoma. When asked how and when did the subdural hematoma occur, the DON stated, "There were no other falls after 4/27/23 until 7/22/23. Don't know how it occurred or when it occurred." Resident 1 is currently in the behavior monitoring room with 1 CNA per shift in the room. The DON stated that this population of patients lose balance easily and falls are inevitable. The DON stated that CNAs try to prevent falls but may be with another resident. Reviewed with the DON Resident 1's Care Plans "Unwitnessed fall with head injury," initiated 7/22/23, and "Resident at risk for falls r/t Dementia, unstudy [sic] gate [sic]," initiated 7/24/23. The DON acknowledged that Resident 1 was always a fall risk and should have had a care plan for fall risk before 7/24/23 and should have had a care plan for fall on 4/27/23. DON stated she will check the care plan history. During an interview on 7/28/23 at 12:37 p.m. with the DON, the DON confirmed that Resident 1 did not have a care plan in the clinical record for fall on 4/27/23 or for any fall prior to 7/22/23 or for fall risk prior to care plan initiated 7/24/23. The DON stated the prior care plans may have been deleted. Reviewed Resident 1's fall on 4/27/23. The DON stated Resident 1 was not sent to the ER, because there was no loss of consciousness and neuro exam was intact. The DON stated Resident 1 had hit his head but no active bleeding and did not need to be transferred to the ER. The	F 689		

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F 689	Continued From page 9 DON stated the subdural hematoma was chronic. Reviewed the acute hospital CT scan on 5/31/23 that indicated it was acute on chronic hematoma and that Resident 1 required ICU care. The DON stated she did not know how the subdural hematoma occurred but acknowledged there was no acute hemorrhage on CT scan after elopement on 4/19/23. A review of the facility policy and procedure (P&P) titled "Falls-Clinical Protocol," revised 4/13, indicated "...As part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling...The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk...the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling...The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved...Delayed complications such as late fractures and major bruising may occur hours or several days after a fall, while sign of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall...If an individual continues to fall, the staff and physician will re-evaluate...the continued relevance of current interventions..." A review of the facility P&P titled "Behavior Intervention & Monitoring Program (BIMP)," revised 5/1/23, indicated "...When BIMP rooms were implemented, it was for those residents who were having challenges in the community due to exhibiting aggressive & sexually inappropriate	F 689		

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F 689	Continued From page 10 behaviors. The rooms were to also be utilized for those who has attempted to elope or has eloped...CNAs assigned to the Behavior Intervention Monitoring Program room will provide all ADL (Activities of Daily Living) to the residents in the room..."	F 689		