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Offer 4/2/12

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA030000105	A. BUILDING _____ B. WING _____	C 08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITNEY OAKS CARE CENTER	3529 WALNUT AVENUE CARMICHAEL, CA 95608

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A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of entity reported incident CA00180376. Representing the Department of Public Health: HFEN, 1958/29917 The inspection was limited to the specific entity reported incident(s) investigated and does not represent the findings of a full inspection of the facility.	A 000	**PLAN OF CORRECTIONS** **"This plan of correction is prepared as part of the quality assurance process for the provider. This plan of correction and any attached documents are prepared with substantial reliance upon privileged peer review information and/or reports and as such are protected from discovery."** **"This plan of correction is prepared, submitted and/or executed solely because it is required by local, state and/or federal regulations, codes, and or guidelines. As this transmission is required by law, it is not a waiver of the provisions within applicable laws and regulations or any other**	
A 163	T22 DIV5 CH3 ART3-72311(a)(1)(A) Nursing Service--General (a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (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. This Statute is not met as evidenced by: Based on interview, medical record and document review the facility failed to plan patient care based on patients' physical and mental assessments, and failed to follow the manufacture's recommendations to ensure that the patient was capable and suitable for transfer on a hydraulic lifting device. These failures resulted in a patient falling from the hydraulic lifting device.	A 163		

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A 163	Continued From page 1 Findings: On 3/22/11, the medical record was reviewed and revealed that Patient A was an 88 year old female, who was re-admitted to the facility on 2/11/09, with diagnoses which included atrial fibrillation, long-term use anticoagulant, mental disorder and history of falls. The Minimum Data Set (MDS-a patient assessment tool), dated 2/23/09, indicated that Patient A was resistive to care, exhibited repetitive physical movements, e.g. hand wringing and restlessness, had poor balance, unsteady gait and was totally dependent in bed mobility, transfer and required extensive assistance from staff. The Assessment for Restraint and Safety Devices, dated 2/12/09, confirmed that the patient had intermittent confusion, was confined to chair and had loss of balance while standing. The patient's Fall Risk Assessment, dated 2/12/09, identified the patient as being chair bound, having balance problems while standing and having intermittent confusion. She ranked 11 on the Fall Risk Assessment which placed Patient A at, "High Risk for falls." Care Plan #1, dated 2/12/09, indicated the patient's physical mobility was impaired, that she exhibited weakness, confusion with dementia and that the patient was occasionally resistive during care. Care Plan #3, dated 2/12/09, indicated that the patient had, "...unsteady gait and balance related to weakness. Poor safety awareness and occasional resistive behavior related to dementia." However, this care plan listed an approach which read, "[Brand name for a stand up lift] lift transfer 1 person."	A 163	**codes, statutes or regulations.** **T22 DIV5 CH3 ART3-72311(a)(1)(A)** Resident A is no longer at the facility. All residents have the potential to be affected by this deficient practice thus the residents' safety dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. This information will then be documented in the residents' plan of care. Upon admission, nursing staff in conjunction with the rehabilitation staff shall assess individual residents' needs for transfer assistance. This information will be	3/24/12

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A 163	Continued From page 2 Care Plan #6, "Potential for injury r/t [related to] anticoagulation therapy..." listed the approach to, "Use extra precautions during transfers & position change." While, Care Plan #10, dated 12/17/09, listed that the patient was combative. In addition, the hospital's History and Physical, dated 2/13/09, warned that the patient exhibited behaviors related to dementia, and that she could, "hit, punch, hurt, pinch, strike out and slap." Nurses Notes dated, 3/7/09 at 7:30 a.m., revealed that CNA 1 was in the process of lifting the patient up to stand while using the stand up Lift. While pulling up her briefs, in attempts to complete dressing her, Patient 1 began moving her arms and slipped them under the support sling. As the CNA attempted to calm her down, the patient pulled both elbows inside the sling belt and fell to her knees, then fell backwards hitting her head on the floor. The patient was taken to the hospital for evaluation and was admitted. In a telephone interview with CNA 1, conducted on 3/24/11 at 2:15 p.m., the CNA indicated that Patient A was swinging her arms and trying to get out of the lift. The patient was, "fighting and was not being cooperative." Referring to Patient A's combative behavior, the CNA further added that, "this has happened before." Upon review of the stand up lift's Operation Manual, dated March 2007, it identified patients not being suited for this type of lift, and warned that, "Patients whose unpredictable behavior during transfers poses risk of injury to patients or staff..." are those who, "frequently exhibit combative behavior during transfers." Additional warnings listed the following:	A 163	relayed to the certified nursing assistants and also documented in the residents care plan. The director of nursing will in service the licensed nurses on policy and procedure on care planning. The director of staff development has in-serviced the certified nurses assistant that all mechanical lifting devices require 2 staff members in attendance. The Minimum data assessment nurse (MDS) will review care plans on a quarterly basis and as needed and make necessary changes based on resident care needs. The director of nursing (DNS) or designee will do random checks on care plans	

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A 163	Continued From page 3 "WARNING: Before using the [Brand name for stand up lift] Lift, patients must be assessed by the facility's professional nursing or rehabilitation staff, to determine which patients are suitable for transfer with [Brand name for stand up lift] Lift." There was no record on file that this was ever done. "WARNING: Patients with unpredictable behaviors due to dementia may require additional help if their behavior poses risk to injury to themselves or to staff members." This warning further indicated that the patient must have cooperative behavior, may not exhibit behaviors that might post risk of injury to the patient and, "be able to bear weight on at least one leg." The facility failed to show evidence that it heeded the above warnings. Patient A's mental disorder, as well as her combative and uncooperative behavior with inability to stand, placed the patient in a category not suitable for transfer by one person assist, on a stand up lift hydraulic lifting device. Due to the patient's limitation in physical functioning, requiring extensive assistance at times, the MDS identified that, two+ persons physical assist was required whenever moving or transferring the patient. However, Care Plan #3, continued to instruct, "1 person [Brand name for stand up lift] lift transfer." The facility failed to show evidence that Patient A was thoroughly assessed and cleared to be determined suitable for 1 person transfer with the stand up lift. Placing Patient A on this lift with just one (1) person assist was contrary to the manufacture's recommendations, which placed	A 163	and follow up with in-services as needed. The DNS will report findings to the QA committee and request recommendations as needed.	

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A 163	Continued From page 4 the patient at high risk for fall or injury.	A 163		
A 822	T22 DIV5 CH3 ART5-72523(a) Patient Care Policies and Procedures (a) Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved. This Statute is not met as evidenced by: Based on interviews, medical record and document review, the facility failed to implement it's own written policy and procedures on Resident Lifting/Assisting Transfer, when it failed to, 1) Initiate an Incident/Accident Report, 2) Initiate a 24 Hour Report following a patient's fall, and 3) Initiate a Post Fall Review following a patient's fall. Findings: On 3/22/11, the medical record review revealed that Patient A was an 88 year old female, who was re-admitted to the facility on 2/11/09, with diagnoses which included atrial fibrillation, long-term use anticoagulant, mental disorder and history of falls. The Minimum Data Set (MDS-a patient assessment tool), dated 2/23/09, indicated that Patient A was resistive to care, exhibited repetitive physical movements, e.g. hand wringing and restlessness, had poor balance, unsteady gait and was totally dependent in bed mobility, transfer and required extensive assistance from staff. The medical record review, conducted on 3/22/11 at 1 p.m., the record documented that on 3/7/09, at about 7:30 a.m., CNA 1 placed the patient on a hydraulic mechanical lift, while attempting to	A 822	**T22 DIV5 CH3 ART5-72523(a)** It is the policy of Whitney Oaks to complete a written report on all incidents/unusual occurrences involving residents. The licensed nurses will complete a written report on incidents and unusual occurrences involving residents. All falls will have a report initiated by the licensed nurse upon discovery of the incident and completed by the end of the shift. This report will be created as an "event" on the matrix computer program and communicated as part of the 24 hour report.	3/24/12

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A 822	Continued From page 5 finish dressing her and preparing her for breakfast. While on the lift, and in the process of standing her up to raise up her briefs, the patient placed both elbows inside the sling belt and fell backwards onto the floor. The facility activated the emergency 911 call system and transferred her to the hospital's emergency department where she was evaluated and admitted. On 3/22/11, at 1:45 p.m., review of the facility's Clinical Policy and Procedure Manual Protocol, titled "Fall Management: Potential and Actual," indicated that in the event of a fall, the facility was to complete the following: -- Incident/Accident Report including notifications -- 24 Hour Report, and -- Initiate Interdisciplinary Post-Fall Review The document further indicated that the facility was to document the falls on the Quality Assurance (QA) Log and the Investigation Report along with the Incident Report would be filed as part of the QA Program. In an interview with the facility Administrator on 3/22/11, at 2 p.m., she indicated that the investigative report regarding this incident was sent to their corporate office. However, on a follow-up call on 3/23/11 at 3 p.m., she acknowledged that none of the above listed items had been conducted as per Facility's policy and confirmed that no investigative report was filed as part of the QA Program. Furthermore, upon review of the facility's policy and procedures on Resident Lifting/Assisting Transfer, the policy indicated that the Director of Nursing Services (DON) or Director of Staff Development (DSD) was responsible for identifying those residents that require lifts and the appropriate type.	A 822	The IDT will review events/falls created on the matrix program on a daily basis and follow up with recommendations as needed. The Director of nursing has in-serviced the Licensed nurses on policy and procedure regarding incident reporting, 24 hour reporting, post fall reviews and creating "events" on the matrix system. Medical records or designee will audit the 24hour report and "events "for compliance and report findings to the administrator and director of nursing. The director of nursing or designee will report to the QA committee and request recommendations as needed based on reported findings.	

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A 822	Continued From page 6 However, there was no record on filed that the DON or DSD had conducted a full evaluation to determine if it would be safe for the patient to use this hydraulic lifting device.	A 822		