PRINTED: 03/12/2014
FORM APPROVED
OMB NO. 0938-0391

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
	056430	A. BUILDING _____ B. WING _____	C 09/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHGATE CARE CENTER	40 PROFESSIONAL CENTER PARKWAY SAN RAFAEL, CA 94903

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an ABBREVIATED STANDARD SURVEY for Entity Reported Number: #CA00353446. Inspection was limited to the Abbreviated Standard Survey and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor # 31424, Health Facilities Evaluator Nurse. One deficiency was issued for Entity Reported Incident: #CA00353446.	F 000	Preparation and/or executive 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 solely because it is required by the provisions of Health and Safety Code Section 1280 and 42 CFR 405.1 Section 7	
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure Resident 1 was free from potential accident hazards, when the facility did not provide adequate supervision and assistance when Resident 1 was ambulating. This failure resulted in Resident 1 falling, sustaining a concussion and fracture to her right upper arm, experiencing increased pain, and	F 323	Resident 1 was immediately assessed for injuries and provided with first aid. Neuro-checks were completed. Resident was transferred to the Emergency room via gurney. Resident 1's physician and family were notified of this occurrence Staff A, Staff B and Staff C were In-serviced on the importance of providing proper Supervision for Residents who have been identified as being a high risk for falls by the RN supervisor on April 16, 2014 As all residents have the potential to be affected by this deficient practice, rounds were completed on May 6, 2013 by the RN supervisor to ensure no other residents who require supervision were left unsupervised. No others were found.	

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

Administrator 4/17/14

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.

Accepted 4/17/14 1630

APR 17 2014

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F 323	Continued From page 1 losing function of her right arm. Findings: During an observation and concurrent interview on 5/09/13 9:50 a.m., Resident 1 was lying in bed with an immobilizer on her right arm and an ice bag applied to her right shoulder. (An immobilizer is a device used to support and protect broken bones while they heal.) Resident 1's right eye was swollen and surrounded by an area of purple bruising which extended down the right side of her face, ending below her jaw line. A 2.5 inch laceration was located above her right eye and was covered with steristrips (thin adhesive strips used to close wounds). Resident 1 stated that on 5/5/13, she got out of bed and attempted to reach her bedside commode (portable toilet with a chair-like frame) which was located at the foot of her bed. She further stated she had used her walker but lost her balance and fell. She reported she had broken her arm in the fall and was now experiencing pain in her right arm. She said she required pain medication to manage the pain. She stated she was no longer able to brush her own teeth or get out of bed to use the bedside commode. She added that when she had to empty her bladder or bowels, she was forced to, "go in the bed." Review of Resident 1's hospital discharge summary indicated Resident 1 suffered a mechanical fall, was admitted to the hospital on 5/5/13 and was discharged back to the facility on 5/7/13. The medical record further revealed under subtitle, "Hospital Course By Problem" that Resident 1 was diagnosed at the hospital with, 1. Right humerus fracture (humerus is the upper arm bone) and 2. Mild concussion and right eye hematoma with laceration. The document further	F 323	Continued An audit was performed by the Medical Records director on April 16, 2014 of all current residents fall risk assessment to ensure any resident with a score of 10 or above and determined to have severely impaired cognitive skills are provided proper supervision. The systemic changes put into place to ensure the alleged deficient practice does not recur will be as follows: Facility staff has been in-serviced on the importance of providing proper Supervision for Residents who have been identified as being a high risk for falls by the RN Supervisor on April 16, 2104. This in-service will be part of orientation of new hires. The facility has implemented a Falling Star Program to ensure residents who are at risk for avoidable and unavoidable falls are identified and plans of care developed and implemented to prevent or minimize falls. The facility staff has been in-serviced on this program by the April 16, 2014. This program will be maintained by the RN Supervisor. The staff member will be stationed in the dining room area at all time when residents are present. The Facility will monitor its performance to insure that solutions are sustained by	

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F 323	Continued From page 2 revealed, "The patient hit her head quite hard when she fell. She had a large hematoma" (collection of blood outside the blood vessels) "over the right eye, which was swollen shut for the last 2 days." Review of facility document titled, "Fall Risk Evaluation" (dated 4/2/13) revealed Resident 1 had balance problems while standing and walking, decreased muscular coordination, unsteady gait and required use of an assistive device (walker). The document further revealed Resident 1 had a history of 1-2 falls in the past 3 months. The document indicated Resident 1 had a total fall score of 12 which represented high risk for falls. Review of facility document titled, "Rehab Screening" (dated 4/9/13) revealed Resident 1 was not steady during transitions (moving on and off toilet, moving between bed and chair and moving from seated to standing position). The document further revealed Resident 1 was not steady while walking (even with a walker) and was, "only able to stabilize with human assistance." The document also indicated that despite Resident 1's unsteady gait (a manner of walking), the facility would not provide skilled interventions for physical therapy as the resident had no insurance coverage to pay for rehabilitation. During an interview on 5/9/13 at 10:30 a.m., Facility Staff A stated that prior to her fall on 5/5/13, Resident 1 got up to her bedside commode without staff assistance and ambulated independently with her walker to the nurses station down the hall. During an interview on 5/9/13 10:45 a.m., Facility Staff B stated that prior to her fall on 5/5/13, Resident 1 usually got up to her bedside commode without staff assistance. She stated	F 323	Continued integrating the plan of correction into the Quality Assurance system. A Safety Quality Assurance audit will be performed by the D.O.N or designee quarterly. The results of this audit will be reported to the Quality Assurance committee for follow-up and recommendations. Completion date April 18, 2014	

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F 323	Continued From page 3 Resident 1 ambulated independently but reported her gait was slow and a little unsteady. Facility Staff B further stated that approximately one hour before Resident 1 fell on 5/5/13, she gave her Norco for back pain. Norco is an opiod pain medication that can cause drowsiness, mental clouding and impaired physical performance (National Library of Medicine). During and interview on 5/9/13 at 1:30 p.m., Facility Staff C stated that Resident 1 was a fall risk because she ambulated with a wide foot stance which made her gait unsteady. He further stated that Resident 1 did not regularly use the call bell to request staff assistance. He said she would call for help when she felt dizzy or wanted the commode cleaned. Review of Resident 1's medical record document titled "Care Plan" subtitled, "ADL's Maintenance" (activity of daily living), dated 4/4/13, revealed a box was checked in front of the intervention, "Monitor ambulation." Review of facility Resident 1's medical record document titled, "CAA Review Report" subtitled, "Summary Notes:" (dated 4/9/13) indicated Resident 1 required staff assistance with balance when standing and transferring. The document further stated staff would provide assistance as needed. Review of Resident 1's medical record document titled, "Care Plan" subtitled, "Falls" (dated 4/4/13) revealed the check boxes in front of bed alarm and chair alarm interventions were not checked. (Bed and chair alarm pads alert caregivers whenever a resident attempts to get up.) During an interview on 5/9/13 at 1:30 p.m., Facility Staff C reported that the facility had placed alarms on Resident 1's bed and chair after she had fallen and fractured her arm.	F 323		