State of California - Hea	Ith and Human Services Agency	Department of Page 1 of 5	Public Health
CITATION NUMBER:	12-2134-0013700-F	<u> </u>	018 Time:
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	UND IN VIOLATION OF APPLICABLE S AND REGULATIONS OR APPLICABLE AND REGULATIONS	Type of Visit : Complaint Investig. Incident/Complaint No.(s) : CA005510	075, CA00550513
Licensee Name:	Spruce Holdings, LLC		
Address:	100 E. San Marcos Boulevard, Suite 200	San Marcos, CA 92069	
License Number:	120000586 Type of Owners	ship: Limited Liability Company	
Facility Name: Address: Telephone: Facility Type: Facility ID:	REDWOOD SPRINGS HEALTHCARE CE 1925 E Houston Ave Visalia, CA 93 Skilled Nursing Facility 120001469	3292	pacity: 176
SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT \$100,000.00	DEADLINE FOR COMPLIANCE 2/5/18 12:00 a.m.
	F323 CFR 483.25 (d) Accidents.  The facility must ensure that - (1) The resident environment remains (2) Each resident receives adequate s accidents.  On 9/12/17, at 10 AM, an unannounce complaint of patient injury. The Depart adequate supervision to Patient 1 whe This resulted in a fall, head injury, and Patient 1 was an 81 year-old female, a diagnoses that included diseases of th difficulty in swallowing, and left-sided w blood supply is cut off to the brain, and move and/or feel a body part). Patient memory.	ed visit was made to the facility to interest the determined the facility failed the she was left unattended while used her subsequent death.  Admitted to the facility on 3/1/17. She heart, muscle weakness, difficult weakness due to a previous stroked can result in paralysis or the loss 1 had moderately impaired thinking	vestigate a to provide ing the toilet.  The had by in walking, coccurs when of ability to g ability and
Name of Evaluator: Carol Erickson Health Fac Evaluat			
Evaluator Signature : .	m. yuman. HEN 1/19/18	Title:	

State of California - Hea SECTION 1424 NOTICE CITATION NUMBER:	Ith and Human Services Agency 12-2134-0013700-F		Department of Public Health Page 2 of 5 Date: 01/19/2018 Time:
SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS		
	During an interview on 9/12/17 at 8:05 AM, Family Me paralyzed on the left foot, arm, and leg. FM 1 stated the 1 on a commode chair (a plastic chair on wheels which must have fallen to the left" and sustained an injury to the Emergency Room (ER), a CT scan (Computerized computer-assisted x-ray) was performed, and stitches on her left forehead. FM 1 stated when she called on she had returned to the facility, and the nurse said, "S "My sister went in at 8 AM and found her not waking ume. I called the nurse and she went to the bedside. The from the fall.' My sister called me and said we need to doctor told me the fall had caused her brain to shift [m. The doctor said we might not see damage for the first They [the facility] shouldn't have left her. They knew should lean to her left." FM 1 stated Patient 1 had since "makeup for the funeral didn't cover up the bruise" on During an interview with Licensed Vocational Nurse (Lishe stated, "I wasn't there [when Patient 1 fell]. I saw (Assistants] looking for a nurse. [Patient 1] was on the [Patient 1] didn't remember what happened. She has I on the commode chair above the toilet. The CNA was pick up clothes."	n goe the le Tom (also Churs he's c p and get h ove] few h he co e diec her fa	is 8/29/17, staff had left Patient is over the toilet) and "she eft eye. Patient 1 was taken to lography, a whown as sutures) placed day morning (8/31/17), after doing great." FM 1 stated, it soaked in sweat and called rise said 'she's probably tired liter back to hospital. The ER and this was the case. In ours and this was the case. In on 9/4/17, and that lace.  If on 9/12/17, at 10:20 AM, it [Certified Nursing bleeding on the left side. It does not be deep analysis. She was sitting to some sitting the solution of the left side.

During a concurrent interview and observation with Certified Nursing Assistant (CNA) 1 on 9/12/17, at 10:45 AM, she stated Patient 1 could not move her left side and "that day me and another CNA [CNA 2] grabbed her pants and put her on the toilet." CNA 1 stated CNA 2 left after Patient 1 was transferred to the toilet and was not present when the fall happened. CNA 1 stated she was going to get Patient 1's shirt out of her closet and "I didn't see what happened. It was so quick." CNA 1 demonstrated going to the closet to get the shirt and when the closet was opened, the patient was out of sight and out of reach of CNA 1.

During an interview on 9/12/17 at 11:15 AM, CNA 2 stated she had helped transfer Patient 1 and did not see the fall.

Patient 1's Minimum Data Set (MDS, a standardized, comprehensive assessment tool)

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

State of California - Health and Human Sepines Agency

**SECTION 1424 NOTICE** 

CITATION NUMBER: 12-2134-0013700-F

Department of Public Health

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Date: 01/19/2018 Time: \_\_\_\_\_

SECTIONS VIOLATED

CLASS AND NATURE OF VIOLATIONS

dated 6/7/17, indicated a BIMS (Brief Interview for Mental Status which evaluates cognition, the ability to remember and think clearly) score of 9, which indicated moderately impaired cognition. The MDS indicated Patient 1 showed difficulty with short-term memory and required the extensive physical assistance of two persons for toilet use. The MDS stated Patient 1 required "two+ persons physical assist" for toilet use. Toilet use is defined in the MDS as "how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag." The instructions for the MDS toileting section indicated "Code for the least steady episode of moving on and off a toilet or portable commode, using an assistive device if applicable."

The MDS also indicated Patient 1 was "Not steady, only able to stabilize with staff assistance" regarding "Moving on and off toilet." The MDS indicated Patient 1 had a "Functional Limitation in Range of Motion," with "Impairment on one side" of her "Upper extremity (shoulder, elbow, wrist, hand)" and her "Lower extremity (hip, knee, ankle, foot)."

Patient 1's Care Plan, dated 3/9/17, stated she needed the assistance of "1-2 person" with toileting, related to a "decline in functional ADL [Activity of Daily Living] activity such as . . . toileting."

Patient 1's Progress Note dated 8/29/17, at 10:44 AM, written by LVN 1 indicated, "Resident [Patient 1, the terms 'patient' and 'resident' can be used interchangeably] was taken to bathroom by CNA on duty. Sat on shower chair, which was placed above the toilet. While CNA turn around to grab resident's clothes from the closet, which is right next to the bathroom, she heard a loud noise. The CNA turn around to check on the resident and resident was found on the floor bleeding from the left side of her eye. The CNA did not actually saw resident falling. Resident did not remember that she fell when asked." Patient 1's Progress Note dated 8/29/17 at 7 PM, written by LVN 1 indicated, "Resident return from [hospital] this evening with 8 stitches to skin tear to left side of eye due to [status post] fall. Slight bleeding noted to sight [sic]."

Patient 1's Progress Note dated 8/31/17, at 11:30 AM, by LVN 2 indicated, "RP [Responsible Party] requesting resident be sent to ER because she feels resident is alerted from her baseline." The Progress Note dated 8/31/17 at 5:59 PM written by LVN 2, indicated, "Resident is being admitted . . . for acute left subdural bleed [a life-threatening injury that occurs when blood vessels rupture between the brain and its

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membranes and the blood presses on the brain tissue]."

During a review of the hospital's clinical record for Patient 1, the documentation titled Physician Documentation, dated 8/29/17, at 9:49 AM indicated, "81 year-old female on Eliquis [a medication that slows the blood's ability to clot] brought in by ambulance after a fall in which she hit her head on tile flooring and sustained a head laceration [cut]. The fall was unwitnessed and patient is unsure if she lost consciousness or not. But a thump was heard by staff at [the facility]. They ran in to help her and she was conscious." The physical exam indicated an 8 centimeter (3.14 inch) laceration to left upper forehead with active bleeding.

The Physician Documentation dated 8/31/17, at 12:19 PM indicated, "The patient is a 81 year-old female who present to the facility with a complaint of AMS [altered mental status]. The symptoms began this morning. . . Family states that patient was not acting herself this morning. . . Had CT done on 8/29/17 which came back normal. History of left sided deficits from previous stroke." The CT of the head report dated 8/31/17, at 12:28 PM indicated, "Compared to prior exam, there is interval development of left holohemispheric subdural hematoma [brain bleeding], measuring up to 1.2 centimeters in size. . . . " The Physician Documentation on 8/31/17, at 12:58 PM indicated, "There was an acute impairment of an organ system with high probability of imminent or life threatening deterioration in the patient's condition." Nursing Notes on 8/31/17, at 1 PM indicated the family did not want to transfer Patient 1 to another hospital and requested comfort care measures. Patient 1 died on 9/4/17.

The hospital document titled Death Summary, dated 10/2/17, indicated "This is an 81-year-old female, who was living at [facility] over the last 6 months. Apparently, she was on the bathroom commode and she fell and hit her head, and she was discharged back to [the facility]. Apparently, the CT at that time showed no acute findings; however, the patient became more and more lethargic [tired or sluggish] and was unable to hold on a conversation, so she was sent back to the emergency room, at which point, there was an interval development of a left-sided subdural hematoma measuring 1.2 centimeters [about 1/2 inch] with a mass effect [a life threatening condition where the hematoma presses against the brain] . . . comfort care measures were initiated given patient's very grave prognosis. Unfortunately, the patient's condition continued to decline and the patient died 9/04/2017."

Patient 1's Death Certificate, dated 9/14/17, stated her "Immediate Cause of Death" was "Respiratory Failure." The "UNDERLYING CAUSE (diseases or injury that initiated

	lth and Human Ser `res Agency		Department of Public Health Page 5 of 5
SECTION 1424 NOTICE CITATION NUMBER:	12-2134-0013700-F		Date: 01/19/2018 Time:
SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS		
	events resulting in death)" were "Acute Subdural Hema Trauma."	tom	a, Acute Closed Head
	During an observation on 9/19/17 at 10:20 AM, the comshower room. On the bottom of the chair was a sticker, never be left unattended or unsupervised."		
	The facility failed to supervise Patient 1 while she was a resulted in her falling and hitting her head on the floor, a Patient 1 died six days later.		Silver and the second control of the second
	This failure presented imminent danger that death or se substantial probability that death or serious physical hawas a direct proximate cause of Patient 1's death.		

[10] 전경 전경 전경 전경 전 전		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	The following reflects the of Public Health during visit:  CLASS AA CITATION 12-2134-0013700-F Complaint(s): CA00551 Representing the Depa Surveyor ID # 2134, Health and the inspection was limed event investigated and findings of a full inspection fundings of a full inspectio	a Complaint Investig  PATIENT CARE  1075, CA00550513  Intment of Public Heal ealth Fac Evaluator Solited to the specific factors and the facility.  Accidents. Interest that Interest that Interest remains as free possible; and the vest adequate supervolve and unannounced visit to a complain artment determined the adequate supervisions is left unattended while in a fall, head injury, arrold female, admitting and diagnoses that in	ation  Ith: up cility ne  ee from ision and  t was nt of he n to le using and her  ed to the cluded		Preparation and/or execution of Correction, inclusive of page through _2_, does not constitut admission or agreement by the the truth of the facts alleged or conclusions set forth in the State Deficiencies. This Plan of Comprehend and/or executed solely is required by provisions of 42 et seq., and Health and Safety (Section 1280. In response to the Department's findings we submisfollowing Plan of Correction we constitute Redwood Springs Carcedible for allegation of compartments.  1. The Resident # 1 no resides in the facility 2. The Director of Nurse (DON) reviewed the falls for the month of December on 12/27/2 ensure the facility state adequate supervision assistance to prevent injury. No other reside found to be affected deficient practice.	es _1_ e an provider of tement of rection is because it CFR 483, Code te hit the hich shall tre Center liance.  DEVICES  longer ting facility facil	
Event ID:141	JH11		1/19/2018	11:	:41:41AM		

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

TITLE

(X6) DATE

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 8

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. State-2567

Page 1 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055604			(X2) MULT A. BUILDIN B. WING	TIPLE CONSTRUCTION  NG	(X3) DATE SURV COMPLETE 12/20	D	
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	walking, difficulty in sw. weakness due to a preblood supply is cut off tparalysis or the loss of body part). Patient 1 hat thinking ability and mer During an interview on Member (FM) 1 stated the left foot, arm, and left P(a plastic chair on whee and "she must have fall an injury to the left eye. Emergency Room (ER) Tomography, a comput performed, and stitches placed on her left foreh called on Thursday more turned to the facility, adoing great." FM 1 state AM and found her not visweat and called me. I went to the bedside. The tired from the fall. My sinced to get her back to me the fall had caused now her brain is bleeding not see damage for the the case. They [the facil They knew she couldn't would lean to her left." I since died on 9/4/17, ar funeral didn't cover up to	vious stroke (occurs of the brain, and can ability to move and/or ad moderately impair mory.  9/12/17 at 8:05 AM, Patient 1 was paraly eg. FM 1 stated that atient 1 on a commodels which goes over len to the left" and sure assisted x-ray) was (also known as sutteed. FM 1 stated who ming (8/31/17), after and the nurse said, 'ed, "My sister went in waking up and soake called the nurse and the nurse said 'she's prister called me and sure nurse said 'she's prister called	when result in or feel a red  Family red on on one ode chair the toilet) ustained in to the uterized as ures) hen she is she had 'She's in at 8 red in a she orobably said we octor told ove] we might this was reft her. She is had the		Certified Nursing A (C. N.A.) & LIcense on Fall Prevention of 10/15/2017. In-service will be prevented the certified nursing and the licensed nurs	ovided to assistants ses ntion on ignee will stimes ivities of sidents n and with injury. Seed to the ssurance low up	

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	During an interview with (LVN) 1 on 9/12/17, at wasn't there [when Pati [Certified Nursing Assis [Patient 1] was on the f [Patient 1] didn't remen has left side paralysis. commode chair above and had turned around. During a concurrent into Certified Nursing Assist 10:45 AM, she stated Pleft side and "that day in grabbed her pants and stated CNA 2 left after the toilet and was not phappened. CNA 1 state Patient 1's shirt out of his what happened. It was demonstrated going to and when the closet was out of sight and out of rousing an interview on stated she had helped to see the fall.  Patient 1's Minimum Dastandardized, comprehedated 6/7/17, indicated Mental Status which ever to remember and think indicated moderately in indicated Patient 1 show indicated Patient 2 indicated Patient 2 indicated Patient 2 indicated Patient 2 indicated P	10:20 AM, she stated ient 1 fell]. I saw CN/stants] looking for a ralloor bleeding on the observation when the toilet. The CNA variants and another CNA put her on the toilet. Patient 1 was transfer each of CNA 1 the closet to get the as opened, the patient 1 was transfer Patient 1 and transfer Pat	d, "I As nurse. left side She ne vas there  fon with l/17, at ove her [CNA 2] " CNA 1 erred to get 't see shirt nt was , CNA 2 d did not  ool) few for e ability l/hich e MDS				
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	bathroom, she heard a around to check on the found on the floor bleed eye. The CNA did not a Resident did not remer asked." Patient 1's Progress Note (Indicated Patient 1's Progress Note (Indicated Progress Note dated 8/LVN 2, indicated Progress Note dated 8/LVN 2, indicated, "Resifor acute left subdural by that occurs when blood brain and its membrane the brain tissue]."  During a review of the Patient 1, the document Documentation, dated 3 indicated, "81 year-old medication that slows the brought in by ambulance her head on tile flooring laceration [cut]. The fall patient is unsure if she But a thump was heard ran in to help her and sphysical exam indicated inch) laceration to left united to the patient of the pati	e resident and resident ding from the left side actually saw resident mber that she fell who gress Note dated 8/2 indicated, "Residenting with 8 stitches to due to [status post] facts of sight [sic]."  The dated 8/31/17, at d., "RP [Responsible is sent to ER because if from her baseline." (31/17 at 5:59 PM writed is being admitted bleed [a life-threatening vessels rupture between and the blood president is and the blood president is a sent to earlier a fall in which grand sustained a head was unwitnessed at lost consciousness of the was conscious." The dand sustained a feel was conscious." The dand sustained (3.)	nt was e of her falling. en 29/17 at t return o skin all.  11:30 Party] she The itten by ed ng injury ween the sses on  ord for n  clot] n she hit ad or not. ty]. They The				
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REDWOOD SPRINGS HEALTHCA	RE CENTER	1925 E Housto	on Ave, Visalia,	CA 93292-2345 TULARE COU	NTY	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEEDED B' R LSC IDENTIFYING INFORM.	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETE DATE
12:19 PM indicated, female who present AMS [altered mental this morning. Fam acting herself this mental sided deficits from phead report dated 8/ "Compared to prior edevelopment of left hematoma [brain ble centimeters in size. Documentation on 8 "There was an acute with high probability deterioration in the photes on 8/31/17, at not want to transfer.	mentation dated 8/31/ "The patient is a 81 ye to the facility with a co status]. The symptom illy states that patient v orning Had CT done back normal. History revious stroke." The C 31/17, at 12:28 PM inc exam, there is interval holohemispheric subduceding], measuring up" The Physician /31/17, at 12:58 PM inc impairment of an orga of imminent or life thre latient's condition." Nu 1 PM indicated the far Patient 1 to another ho ort care measures. Pat	ear-old mplaint of as began vas not e on of left T of the dicated, aral to 1.2 dicated, an system eatening rsing mily did aspital				
10/2/17, indicated "T who was living at [fa Apparently, she was she fell and hit her h back to [the facility]. showed no acute fin became more and m and was unable to h was sent back to the	ent titled Death Summa this is an 81-year-old fo cility] over the last 6 m on the bathroom com- ead, and she was disc Apparently, the CT at dings; however, the pa fore lethargic [tired or so old on a conversation, e emergency room, at we interval development of	emale, onths. mode and charged that time atient sluggish] so she which				

11:41:41AM

AND PLAN OF	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU 055604	JMBER:	A. BUILDIN B. WING		(X3) DATE SUR COMPLET	
	OVIDER OR SUPPLIER	CENTED	STREET ADDRESS			#	
KEDWOOL	O SPRINGS HEALTHCARE	CENTER	1925 E Houston	Ave, visalia	, CA 93292-2345 TULARE COUNTY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	'FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETE DATE
	left-sided subdural hem centimeters [about 1/2 life threatening condition presses against the brameasures were initiated prognosis. Unfortunated continued to decline an 9/04/2017."  Patient 1's Death Certificher "Immediate Cause Failure." The "UNDERLINITY that initiated ever "Acute Subdural Hemat Trauma."  During an observation of commode chair was no bottom of the chair was "Patient must never be unsupervised."  The facility failed to sup was using the toilet. The falling and hitting her her bleeding inside her skullater.  This failure presented in serious harm would rest that death or serious phetherefrom, and was a different 1's death.	inch] with a mass effor where the hemators in which satisfies a failure resulted in a shower room a sticker, which startleft unattended or hervise Patient 1 which is a failure resulted in ead on the floor, cault. Patient 1 died six mminent danger that ult or substantial propysical harm would resulted in a shower which startleft unattended or hervise Patient 1 which is a failure resulted in the floor, cault.	fect [a ma				
Event ID:141	JH11		1/19/2018	11:4	11:41AM		

STATEMENT OF DEFICIENCIES (X1) PI AND PLAN OF CORRECTION ID:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		1000		A. BUILDIN	IG			
		055604		B. WNG	9	12/2	0/2017	
NAME OF PRO	VIDER OR SUPPLIER		STREET ADDRESS,	CITY, STATE,	ZIP CODE			
REDWOOD	SPRINGS HEALTHCARE	CENTER			, CA 93292-2345 TULARE COU	NTY		
			L					
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY		ID	PROVIDER'S PLAN OF C		(X5)	
TAG		SC IDENTIFYING INFORMA		PREFIX TAG	(EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	RIATE DEFICIENCY)	COMPLETE DATE	
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