SECTION 1424 NOTICE

CITATION NUMBER: 08-2111-0006919-F

Date: 02/03/2010 Time: 10:20AM

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Type of Visit : Complaint Investig.
Incident/Complaint No.(s) : CA00207618

Licensee Name: Villa Rancho Bernardo Health Care, LLC

Address: 3050 SATURN STREET SUITE 201 BREA, CA 92821

License Number: 080000316 Type of Ownership: Limited Liability Company

Facility Name: VILLA RANCHO BERNARDO CARE CENTER
Address: 15720 BERNARDO CENTER DRIVE SAN DIEGO, CA 92127
Telephone: (858)672-3900
Facility Type: Skilled Nursing Facility Capacity: 299
Facility ID: 080000694

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $100,000.00	DEADLINE FOR COMPLIANCE 2/10/10 12:01 a.m.
F483.25(h)	**CLASS** AA **CITATION -- ACCIDENTS & SUPERVISION**		

The following reflects the findings of the California Department of Public Health during the investigation of complaint.

Complaint #CA00207618

Regarding: Accidents

The investigation was limited to the specific complaint/self reported event investigated and does not represent the findings of a full inspection of the facility.

Representing the Department of Public Health:
[redacted] HFEN

F323
483.25(h) Accidents
The facility must ensure that -
(1) The resident environment remains as free from accident hazards as is possible; and
(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

The facility failed to supervise a wheel chair bound resident who had displayed wandering and exit seeking behaviors approximately 40 minutes prior to the accident.

Name of Evaluator:
[redacted]
HFEN

Evaluator Signature [redacted]

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature :

Name : ROBERT DURBIN

Title : ADMINISTRATOR

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

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	Despite the facility having a Care Plan which directed staff to keep the Resident in an observed area and despite the facility policies which directed staff actions in the event of door alarm activation, Resident A was still able to exit the alarmed emergency door. On [redacted]/09 at approximately 3:30 P.M., Resident A exited an alarmed emergency door onto a stairwell landing. The resident then pushed open a second metal door and, while secured in his wheel chair, the resident tumbled down a concrete stairwell, landing at the base of the stairs. The resident was transported to a nearby hospital, where he died [redacted]/09 from injuries sustained during the fall. On 11/19/09 at 2:50 P.M., Immediate Jeopardy [IJ] was called as the facility did not have an adequate system in place to ensure that other residents who exhibited wandering behavior on the 2nd floor where Resident A resided, did not exit the emergency doors. Seven (7) other residents besides Resident A were identified as exhibiting wandering behavior. On 11/19/09 at 5:34 P.M., the IJ was abated after a credible plan of correction was received from the facility. The plan of correction included the following: 1. A 24-hour monitoring system was developed that included designated employees who would monitor the emergency exits. 2. Residents with wandering and elopement behavior will be identified and assessed. 3. In-service education on monitoring will be completed by 11/30/09. 4. Education of employees will include how to respond to alarms, and how to turn alarms on and off. 5. Delayed door release system will be installed on all emergency exits. Findings: Resident A was admitted to the facility on [redacted]/09 with diagnoses that included [redacted] and [redacted] according to the Admission/Discharge Summary. According to the resident's Minimum Data Set assessment (MDS) Resident A's cognitive skills for daily decision making indicated that the resident had modified independence and difficulty in new situations only. Review of the resident's medical record revealed a Care Plan, documenting that Resident A was at risk for falling and injury related to his [redacted], congenital anomalies on hands (no fingers), and his history of falls. The Care Plan also documented, "Approach Plan" [redacted]/09, "keep resident in observed area while in WC [wheelchair] and soft belt while in WC for safety."

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	The facility's report of the incident, on [redacted]/09 at 2:30 P.M., noted that Resident A was seen by the staff sitting in a wheelchair (WC) in front of the nurse's station. At 3:15 P.M., the resident was seen in the hallway. At 3:25 P.M., the door alarm on the East exit door of the facility went off. There was a cement landing outside the East exit door. A metal grate door with a push handle was to the right of the alarmed exit door. When the metal grate door was pushed opened, there was one flight of cement stairs which lead down to the ground level. Resident A exited through the alarmed East door, and then opened the metal grate door. The resident was discovered on the ground at the bottom of the cement stairs lying on his right side while still in his WC. Two people were outside the building and saw the resident on the ground. One person went for assistance, and the other person called for emergency personnel. On 11/18/09 an observation was made of the East stairwell on the second floor at the facility. The Door Alarm log was then reviewed. The Door Alarms had been checked and found to be working between 1/09 and 11/09. The door alarms were checked monthly according to the maintenance Supervisor. According to the Nurses' Notes for [redacted]09 at 2:30 P.M., Resident A was in front of the Nurses' station. Per the Notes, "The resident was alert and responsive to both verbal and physical stimuli." During an interview with CNA 6 on 11/19/09 at 2:15 P.M., the CNA said that on the date of the incident [[redacted]09], "The alarm went off and Licensed Nurse 1 [LN 1] and the Restorative Nursing Assistant (RNA) responded. The resident was at the exit door, they turned him back to the nurse's station. This happened around 2:40 P.M. On 11/19/09 at 9:30 A.M., the Supervisor was interviewed. She said that she was, "In the reception area in the front lobby" when she was told there was a resident lying on the ground and she was directed towards the East stairwell. The Supervisor went on to state that she ran outside and saw the Resident lying on the ground. The Resident was still in his wheelchair. The Supervisor said, "I then ran up the stairs and knocked on the exit door. Licensed Nurse 1 [LN 1] opened the door and I told her that Resident A was on the ground. Per the Supervisor, "The Resident was bleeding from the head and ear, pressure was applied to the head wound" and the emergency personnel had arrived and took over care of the Resident.

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	According to the Nurses Notes dated [redacted]/09, the paramedics (emergency personnel) arrived at the facility at 3:35 P.M. The Resident was transferred to the hospital at 3:50 P.M. The facility's Director of Nursing [DON] interviewed Licensed Nurse 1 [LN 1] on 11/11/09. On 11/19/09 documentation of the interview was reviewed. LN 1 was unavailable for interview by the Department. Per this interview record, LN 1, "Thought she heard an alarm pause a little bit and then she quickly walked to the emergency exit door...She [LN 1] then turned off the sound, she looked outside from inside (door) she heard the Supervisor knocking, she opened the door and the Supervisor told her to go downstairs to check and stay with the Resident." The emergency personnel arrived about 8-10 minutes later and took over care of the Resident. LN 1 was asked by the DON if someone had called her attention to the incident and LN 1 stated, "No." The facility's Director of Nursing [DON] interviewed Licensed Nurse 2 [LN 2] on 11/9/09 at 2:00 P.M. On 11/19/09 documentation of the interview was reviewed. LN 2 was unavailable for interview by the Department. Per this interview record, Resident A had been placed in the dining area in front of the Nurses' station. Per the interview record, "The resident propels self around; he is fast, in a matter of minutes he would be gone from where he was." "We (nursing staff) have been taking turns to watch him in Nurses station/dining room." Per the interview record, LN 2 was located in another hallway at the time when the door alarm went off and taking vital signs and giving medication. Per the interview, LN 2 could have heard the alarm, but she had a stethoscope (used to transmit sounds in the body to the nurse's ears) and was giving medications to another resident. "The next thing she knew the Supervisor is telling her the resident had an accident.." The Interdisciplinary Team (IDT) notes dated 11/9/09 supported CNA 6's statement that Resident A previously attempted to exit through the alarmed door on [redacted]09. Per the IDT notes, "The resident is up in wc daily for safety monitoring every 2 hours, needs to be in observed area when in wc. [redacted]09, with wandering behavior propels himself in and out of room, on way to hallways or in front of nurses' station. Staff started to watch and keeping him in dining room for meals, activities, in Nurses' station or front of nurses station for monitoring his behavior." On 11/19/09 the facility's policy, "Actions to take in event of door alarm activation or general power outage in the facility" were reviewed. Per the facility policy, "It is the policy

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	of the facility, upon activation of any door alarm .....to ensure the continued safety of all residents is maintained. The facility has established procedures for accurately identifying and quickly locating any resident, who is determined or believed to be missing from the facility." Procedure: 1. In the event of Alarm: a. Determine which door was activated. b. Visually inspect each door to see if open or if any resident's are near or outside door. 2. Immediately conduct resident count to ensure all residents on unit can be accounted for. On 11/18/09 an observation was made of the East stairwell on the second floor at the facility. The exit door had an alarm that emitted a high pitched sound when opened. There was a cement landing outside the exit door. The stairway was to the right and was entered by going through a metal grate door with a push handle. The Door Alarm log was then reviewed. The Door Alarms had been checked and found to be working between 1/09 and 11/09. The door alarms were checked monthly according to the maintenance Supervisor. Resident A exited the building through the alarmed emergency door and fell down 20 steps onto a concrete landing at the base of the stairs while still secured in his wheelchair by a soft belt restraint. The resident suffered multiple lacerations on face, scalp with bright red blood coming out of left ear per the emergency department flow. Resident A was admitted to the hospital with diagnoses of, "Acute fall with clinical basilar skull fracture, left maxillary sinus fracture, scalp hematoma and hemo tympanum [blood in the middle ear] per the Emergency Physician documentation. Resident A died on [redacted]09. According to the autopsy report, the cause of death of Resident A was, "Complications following blunt force trauma of the head and torso." The facility failed to supervise a wheel chair bound resident who had displayed wandering and exit seeking behaviors. Despite the facility having a Care Plan which directed staff to keep the Resident in an observed area, and despite the facility policies which directed staff actions in the event of door alarm activation, Resident A was still able to exit the alarmed emergency door unobserved. The facility's failure to supervise Resident A 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 patient.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555318	A. BUILDING B. WING	02/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA RANCHO BERNARDO CARE CENTER	15720 BERNARDO CENTER DRIVE, SAN DIEGO, CA 92127 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit. Representing the Department of Public Health: [redacted] HFEN CLASS AA CITATION -- ACCIDENTS & SUPERVISION 08-2111-0006919-F Complaint(s): CA00207618 The following reflects the findings of the California Department of Public Health during the investigation of complaint. Complaint #CA00207618 Regarding: Accidents The investigation was limited to the specific complaint/self reported event investigated and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: [redacted] HFEN F323 483.25(h) Accidents The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.		Preparation and/or execution 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. This Plan of Correction is prepared and/or executed because it is required by the provisions of Health and Safety Code Section 1250 and 42 C.F.R.405.1907. On November 9, 2009, a Hall Monitoring System was developed by the Administrative and Nursing Managers to formalize the program. Forms were developed to provide for documentation and a means	2/10/10

Event ID:IGZ911 2/2/2010 8:39:36AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2-3-10

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.

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	Continued From page 1 The facility failed to supervise a wheel chair bound resident who had displayed wandering and exit seeking behaviors approximately 40 minutes prior to the accident. Despite the facility having a Care Plan which directed staff to keep the Resident in an observed area and despite the facility policies which directed staff actions in the event of door alarm activation, Resident A was still able to exit the alarmed emergency door. On [redacted]09 at approximately 3:30 P.M., Resident A exited an alarmed emergency door onto a stairwell landing. The resident then pushed open a second metal door and, while secured in his wheel chair, the resident tumbled down a concrete stairwell, landing at the base of the stairs. The resident was transported to a nearby hospital, where he died [redacted]09 from injuries sustained during the fall. On 11/19/09 at 2:50 P.M., Immediate Jeopardy [IJ] was called as the facility did not have an adequate system in place to ensure that other residents who exhibited wandering behavior on the 2nd floor where Resident A resided, did not exit the emergency doors. Seven (7) other residents besides Resident A were identified as exhibiting wandering behavior. On 11/19/09 at 5:34 P.M., the IJ was abated after a credible plan of correction was received from the facility. The plan of correction included the following:		of monitoring the system. Inservice education was started for the Nursing staff on the Hallway Monitoring System by the Directors of Staff Development and all the Nursing Staff will be trained by November 30, 2009. The Nursing Managers identified residents on the second floor with independent locomotion, then further assessed for wandering and/or elopement behavior. Residents identified as wandering and or elopement risk were placed on One on One monitoring by nursing staff or placed in the facility's Dementia Unit during waking hours. All residents will be assessed using the Elopement Risk Assessment form by November 30, 2009. High Risk residents will not be placed on the 2nd floor rooms. Inservice education regarding the Hall Monitoring Program and One on	2/10/10

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	Continued From page 2 1. A 24-hour monitoring system was developed that included designated employees who would monitor the emergency exits. 2. Residents with wandering and elopement behavior will be identified and assessed. 3. In-service education on monitoring will be completed by 11/30/09. 4. Education of employees will include how to respond to alarms, and how to turn alarms on and off. 5. Delayed door release system will be installed on all emergency exits. Findings: Resident A was admitted to the facility on [redacted]/09 with diagnoses that included [redacted] and [redacted] according to the Admission/Discharge Summary. According to the resident's Minimum Data Set assessment (MDS) Resident A's cognitive skills for daily decision making indicated that the resident had modified independence and difficulty in new situations only. Review of the resident's medical record revealed a Care Plan documenting that Resident A was at risk for falling and injury related to his [redacted] congenital anomalies on hands (no fingers), and his history of falls. The Care Plan also documented, "Approach Plan" [redacted]09, "keep resident in observed area while in WC [wheelchair] and soft belt while in WC for safety."		One supervision continues with the Nursing staff and will be completed on November 30, 2009. The Exit Door Alarm and Response Training continues with all staff and will be completed on November 30, 2009. The Exit Door Alarm and Response Training will include alarm codes to arm and disarm the system, procedures to be taken when the alarm is activated and notification of the supervisor of charge nurse of an alarm condition. Method of training will be return demonstration. The Licensed Nurses were re-educated by the Director of Nursing and the Facility's Nurse Consultant regarding identification and assessment of residents displaying wandering/ elopement behaviors on November 20 and 23 2009. On November 12, 2009, the facility' alarm company, JJJ Enterprise, was on site to evaluate the second floor exit doors for "delayed egress" door	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555318	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/03/2010
NAME OF PROVIDER OR SUPPLIER: VILLA RANCHO BERNARDO CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 15720 BERNARDO CENTER DRIVE, SAN DIEGO, CA 92127 SAN DIEGO COUNTY		

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	Continued From page 3 The facility's report of the incident, on [redacted]09 at 2:30 P.M., noted that Resident A was seen by the staff sitting in a wheelchair (WC) in front of the nurse's station. At 3:15 P.M., the resident was seen in the hallway. At 3:25 P.M., the door alarm on the East exit door of the facility went off. There was a cement landing outside the East exit door. A metal grate door with a push handle was to the right of the alarmed exit door. When the metal grate door was pushed opened, there was one flight of cement stairs which lead down to the ground level. Resident A exited through the alarmed East door, and then opened the metal grate door. The resident was discovered on the ground at the bottom of the cement stairs lying on his right side while still in his WC. Two people were outside the building and saw the resident on the ground. One person went for assistance, and the other person called for emergency personnel. On 11/18/09 an observation was made of the East stairwell on the second floor at the facility. The Door Alarm log was then reviewed. The Door Alarms had been checked and found to be working between 1/09 and 11/09. The door alarms were checked monthly according to the maintenance Supervisor. According to the Nurses' Notes for [redacted]09 at 2:30 P.M., Resident A was in front of the Nurses' station. Per the Notes, "The resident was alert and responsive to both verbal and		locks. A proposal was developed and verbal approval was obtained by Villa Rancho Bernardo's owner. Plans and permits have been developed and submitted to the State of California, Office of Statewide Health Planning and Development (OSHPD) and the State Fire Marshall for approval before installation. The Hall Monitoring Program will be continued 24 hours a day/seven days a week until the Delay Egress system is installed. The Licensed Nursing Staff will be instructed by the DSDs to notify the DNS verbally and complete an investigation report for any resident exhibiting wandering/elopement behavior. Investigation reports will be presented to the facility's 24 hr report meeting for review and implementation of additional interventions. This training will be completed by November 30,	2/10/10

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	555318	A. BUILDING B. WING	02/03/2010

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	Continued From page 4 physical stimuli." During an interview with CNA 6 on 11/19/09 at 2:15 P.M., the CNA said that on the date of the incident [redacted]09], "The alarm went off and Licensed Nurse 1 [LN 1] and the Restorative Nursing Assistant (RNA) responded. The resident was at the exit door, they turned him back to the nurse's station. This happened around 2:40 P.M. On 11/19/09 at 9:30 A.M., the Supervisor was interviewed. She said that she was, "In the reception area in the front lobby" when she was told there was a resident lying on the ground and she was directed towards the East stairwell. The Supervisor went on to state that she ran outside and saw the Resident lying on the ground. The Resident was still in his wheelchair. The Supervisor said, "I then ran up the stairs and knocked on the exit door. Licensed Nurse 1 [LN 1] opened the door and I told her that Resident A was on the ground. Per the Supervisor, "The Resident was bleeding from the head and ear, pressure was applied to the head wound" and the emergency personnel had arrived and took over care of the Resident. According to the Nurses Notes dated [redacted]09, the paramedics (emergency personnel) arrived at the facility at 3:35 P.M. The Resident was transferred to the hospital at 3:50 P.M.		2009. Compliance will be monitored by the Director of Nursing Services through review of the investigation reports and 24 hr report. A summary of compliance with the Wander/Elopement Program will be reported by the DNS OR Designee to the facility's monthly CQI Committee. Inservice regarding interventions for Wandering, Elopement or Missing Residents will be included during the facility's semi-annual Safety Education.	2/10/10

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	Continued From page 5 The facility's Director of Nursing [DON] interviewed Licensed Nurse 1 [LN 1] on 11/11/09. On 11/19/09 documentation of the interview was reviewed. LN 1 was unavailable for interview by the Department. Per this interview record, LN 1, "Thought she heard an alarm pause a little bit and then she quickly walked to the emergency exit door...She [LN 1] then turned off the sound, she looked outside from inside (door) she heard the Supervisor knocking, she opened the door and the Supervisor told her to go downstairs to check and stay with the Resident." The emergency personnel arrived about 8-10 minutes later and took over care of the Resident. LN 1 was asked by the DON if someone had called her attention to the incident and LN 1 stated, "No." The facility's Director of Nursing [DON] interviewed Licensed Nurse 2 [LN 2] on 11/9/09 at 2:00 P.M. On 11/19/09 documentation of the interview was reviewed. LN 2 was unavailable for interview by the Department. Per this interview record, Resident A had been placed in the dining area in front of the Nurses' station. Per the interview record, "The resident propels self around; he is fast, in a matter of minutes he would be gone from where he was." "We (nursing staff) have been taking turns to watch him in Nurses station/dining room." Per the interview record, LN 2 was located in another hallway at the time when the door alarm went off and taking vital signs and giving medication. Per the interview, LN 2 could have heard the alarm, but she had a stethoscope			

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VILLA RANCHO BERNARDO CARE CENTER	15720 BERNARDO CENTER DRIVE, SAN DIEGO, CA 92127 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
	Continued From page 6 (used to transmit sounds in the body to the nurse's ears) and was giving medications to another resident. "The next thing she knew the Supervisor is telling her the resident had an accident.." The Interdisciplinary Team (IDT) notes dated 11/9/09 supported CNA 6's statement that Resident A previously attempted to exit through the alarmed door on [redacted]/09. Per the IDT notes, "The resident is up in wc daily for safety monitoring every 2 hours. needs to be in observed area when in wc. [redacted]09, with wandering behavior propels himself in and out of room, on way to hallways or in front of nurses' station. Staff started to watch and keeping him in dining room for meals, activities, in Nurses' station or front of nurses station for monitoring his behavior." On 11/19/09 the facility's policy, "Actions to take in event of door alarm activation or general power outage in the facility" were reviewed. Per the facility policy, "It is the policy of the facility, upon activation of any door alarm .....to ensure the continued safety of all residents is maintained. The facility has established procedures for accurately identifying and quickly locating any resident, who is determined or believed to be missing from the facility." Procedure: 1. In the event of Alarm: a. Determine which door was activated. b. Visually inspect each door to see if open or			

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555318	A. BUILDING B. WING	02/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA RANCHO BERNARDO CARE CENTER	15720 BERNARDO CENTER DRIVE, SAN DIEGO, CA 92127 SAN DIEGO COUNTY

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	Continued From page 7 if any resident's are near or outside door. 2. Immediately conduct resident count to ensure all residents on unit can be accounted for. On 11/18/09 an observation was made of the East stairwell on the second floor at the facility. The exit door had an alarm that emitted a high pitched sound when opened. There was a cement landing outside the exit door. The stairway was to the right and was entered by going through a metal grate door with a push handle. The Door Alarm log was then reviewed. The Door Alarms had been checked and found to be working between 1/09 and 11/09 The door alarms were checked monthly according to the maintenance Supervisor. Resident A exited the building through the alarmed emergency door and fell down 20 steps onto a concrete landing at the base of the stairs while still secured in his wheelchair by a soft belt restraint. The resident suffered multiple lacerations on face, scalp with bright red blood coming out of left ear per the emergency department flow. Resident A was admitted to the hospital with diagnoses of, "Acute fall with clinical basilar skull fracture, left maxillary sinus fracture, scalp hematoma and hemo tympanum [blood in the middle ear] per the Emergency Physician documentation. Resident A died on [redacted]09. According to the autopsy report, the cause of death of Resident A was, "Complications following blunt force trauma of the head and torso."			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555318	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/03/2010
NAME OF PROVIDER OR SUPPLIER VILLA RANCHO BERNARDO CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 15720 BERNARDO CENTER DRIVE, SAN DIEGO, CA 92127 SAN DIEGO COUNTY		

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	Continued From page 8 The facility failed to supervise a wheel chair bound resident who had displayed wandering and exit seeking behaviors. Despite the facility having a Care Plan which directed staff to keep the Resident in an observed area, and despite the facility policies which directed staff actions in the event of door alarm activation, Resident A was still able to exit the alarmed emergency door unobserved. The facility's failure to supervise Resident A 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 patient.			

Event ID:IGZ911 2/2/2010 8:39:36AM

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