

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055872</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/28/2007</b>
NAME OF PROVIDER OR SUPPLIER <b>CITRUS NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>9440 CITRUS AVENUE, FONTANA, CA 92335 SAN BERNARDINO COUNTY</b>		
(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) COMPLETE DATE
	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit.</p> <p>Representing the Department of Public Health: [REDACTED]</p> <p>CLASS AA CITATION -- PATIENT CARE 24-2042-0004343-S Complaint(s): CA00107656, CA00107421, CA00107476 72311(a)(2) Nursing Services General</p> <p>(a) Nursing service shall include, but not be limited to, the following: (2) Implementing of each patient's care plan according to the methods indicated. Each patient's care shall be based on this plan.</p> <p>72523(a) Patient Care Policies and Procedures</p> <p>(a) Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved.</p> <p>During a complaint investigation on February 28, 2007, it was determined the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Implement Patient 1's care plan according to the methods indicated when transferring Patient 1 with a Hoyer Lift (a portable lifting machine) as evidenced by only one person performed transfer.</li> <li>2. Implement their written policy for using a portable lifting machine (Hoyer Lift) to ensure that patient related goals are achieved as evidenced by only one person instead of the required two performed the lift.</li> </ol>			

Event ID:PD4M11

11/28/2007

4:49:35PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055872</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/28/2007</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>CITRUS NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>9440 CITRUS AVENUE, FONTANA, CA 92335 SAN BERNARDINO COUNTY</b>
--	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p><b>Continued From page 1</b></p> <p>Based on interview and record review the facility's failure to implement Patient 1's care plan and the facility's policy and procedure for Hoyer Lift resulted in Patient 1 being dropped on her head by facility staff on February 24, 2007 and dying nine days later on March 5, 2007.</p> <p>On February 28, 2007, a record review showed Patient 1, a 91 year-old female, was originally admitted to the facility on June 5, 2000 and readmitted on September 6, 2005 with diagnoses that included cerebral vascular accident (stroke) with left side weakness, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), depression, hypertension, paroxysmal supra-ventricular tachycardia (a fast heart beat that happens time to time), and asthma. Patient 1's daughter was shown as Responsible Party on Admission/Discharge Summary.</p> <p>Licensed staff documented on Nurses Notes dated January 14, 2007 at 7 p.m. Patient 1 was alert with confusion.</p> <p>Review of the Minimum Data Set (MDS) dated February 16, 2007 showed Patient 1 had short and long term memory problems and had moderately impaired decision making abilities. The MDS also showed Patient 1 was dependent on facility staff for all activities of daily living (for example moving in bed, dressing, eating) and needed two plus persons to assist with transfers.</p> <p>During interview February 28, 2007 at 2:15 p.m., the Director of Staff Development (DSD) stated that an in-service on correct Hoyer Lift use was given by her (DSD) on February 9, 2007 (15 days before incident).</p>			
--	---	--	--	--

Event ID:PD4M11

11/28/2007

4:49:35PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055872</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/28/2007</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>CITRUS NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>9440 CITRUS AVENUE, FONTANA, CA 92335 SAN BERNARDINO COUNTY</b>
--	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p><b>Continued From page 2</b></p> <p>The in-service required each CNA to demonstrate proper two person transfer with Hoyer Lift while the DSD watched. The DSD stated that she told the CNAs "remember it is a two person technique" when she showed them (CNAs) where the Hoyer Lift was kept, during orientation. "I tell everyone" the DSD stated.</p> <p>Review of sign-in sheet for In-Service dated February 9, 2007 revealed in-service topics which included Hoyer Lift. On signature line, CNA 1's name was written which signifies her attendance.</p> <p>Review of written statement from Certified Nurse Assistant (CNA) 1 on February 24, 2007, revealed CNA 1 used Hoyer Lift to transfer Patient 1 from wheelchair to bed.</p> <p>During an interview with CNA 1 on February 28, 2007 at 2:45 p.m., she stated when she raised Patient 1 with Hoyer Lift one leg came loose and Patient 1 started to fall. CNA 1 stated "... (I) tried to hold her but couldn't hold head just the body. Head hit floor."</p> <p>Review of Nurses Notes dated February 24, 2007, 7:20 p.m. revealed Licensed Vocational Nurse (LVN) 1 was called to Patient 1's room and found Patient 1 on floor with "blood fresh from back of her head."</p> <p>Review of LVN 1 written statement dated February 24, 2007 revealed Patient 1 did not respond when she called Patient 1's name and touched Patient 1's face.</p> <p>Interview on February 28, 2007 at 2:15 p.m. with LVN 1 revealed the same information as documented on her written statement.</p> <p>On February 28, 2007, review of Patient 1's medical</p>			
--	--	--	--	--

Event ID:PD4M11

11/28/2007

4:49:35PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055872</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/28/2007</b>
NAME OF PROVIDER OR SUPPLIER <b>CITRUS NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>9440 CITRUS AVENUE, FONTANA, CA 92335 SAN BERNARDINO COUNTY</b>		
(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) COMPLETE DATE
	<p><b>Continued From page 3</b></p> <p>records revealed a care plan for self care deficit. One of the care plan interventions was for "Hoyer Lift two transfer assist".</p> <p>Same day review of facility's policy and procedures for using a portable lifting machine (Hoyer Lift) revealed 2 staff were required if patient could not help.</p> <p>On February 24, 2007 at 7:50 p.m., the nurses' notes documented that an ambulance arrived. Patient 1 was admitted to an acute care hospital on same day and died nine days later March 5, 2007.</p> <p>The facility staff failed to follow Patient 1's care plan and their policy for transferring with Hoyer Lift. Patient 1 was dropped on the floor; hit her head; and died from blunt force head injury, as documented on death certificate.</p> <p>The Certificate of Death reflected Patient 1 died on March 5, 2007 from a "blunt force head injury." The coroner documented "Patient dropped from Hoyer Lift while staff was moving her from a wheelchair into her bed."</p> <p>The facility staff failed to meet the regulations as follows:</p> <ol style="list-style-type: none"> <li>1. Implement Patient 1's care plan according to the methods indicated when transferring Patient 1 with a Hoyer Lift (a portable lifting machine) as evidenced by only one person performed transfer.</li> <li>2. Implement their written policy for using a portable lifting machine (Hoyer Lift) to ensure that patient related goals are achieved as evidenced by only one person instead of the required two performed the lift.</li> </ol>			

Event ID:PD4M11

11/28/2007

4:49:35PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055872</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/28/2007</b>
NAME OF PROVIDER OR SUPPLIER <b>CITRUS NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>9440 CITRUS AVENUE, FONTANA, CA 92335 SAN BERNARDINO COUNTY</b>		
(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) COMPLETE DATE
	<p><b>Continued From page 4</b></p> <p>These violations presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result and were a direct proximate cause of the death of the patient.</p>			

Event ID:PD4M11

11/28/2007

4:49:35PM

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.