

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>555702  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                            | (X3) DATE SURVEY COMPLETED<br><br>12/26/2007   |
| NAME OF PROVIDER OR SUPPLIER<br>Bakersfield Healthcare Center |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>730 34TH STREET, BAKERSFIELD, CA 93301 KERN COUNTY |  |
| {X4} 10 PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)  | 10 PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  |
|   | <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:<br/>[REDACTED] HFEN</p> <p>CLASS AA CITATION - PATIENT CARE<br/>12-2134-0006727-S<br/>Complaint(s): CA00135552</p> <p>T22. 72311 (a)(1)(B)(C)(2) - Nursing Service-General<br/>(a) Nursing service shall include but not be limited to, the following:<br/>(1) Planning of patient care, which shall include at least the following:<br/>(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.<br/>(B) Development of an individual, written patient care plan which indicates the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited.<br/>(c) Reviewing, evaluating and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the<br/>(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>The resident identified received treatment at the time of occurrence on December 15, 2007.</p> <p>Residents at risk for falls have been reviewed by Director of Nurses to ensure that a plan of care for fall risk has been completed. Those identified with high risk of 10 or greater are re-evaluated by Social Service for cognitive status using a mental status tool. Additionally those who score a 15 on the fall risk will then be assessed for Bowel and Bladder. The highest risks are then prioritized to begin a bowel and bladder program. New admission's records are reviewed within 24/ 72 hours during the morning meeting by the Director of Nurses for accuracy of assessments.</p> |

2/03/2010

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Event ID: 4GH311 1/19/2010  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

9:07:07AM  
TITLE ADMINISTRATOR (X6) DATE 1/29/2010

Any deficiency statement ending with an asterisk (\*) denotes a condition that other than the institution may be providing it is determined 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.

Accepted Yaelle Chardacoste HFES for L. Melvinson D.O. 1 of 7

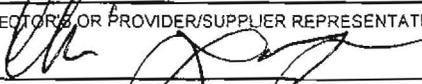
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|  | <p>I Continued From page 1</p> <p>On December 26, 2007 an unannounced visit was made to the facility to investigate a self-reported incident involving a resident who fell, suffered a head injury and subsequently died.</p> <p>Based on interview, observation, and record review, the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Accurately assess Patient 1 and implement a fall risk care plan within seven days after admission.</li> <li>2. Accurately assess and implement care plans for Patient 1 which identifies memory deficits, bowel/bladder continence, and safety needs.</li> <li>3. Review and update care plans for Patient 1 Which identifies fall risk, memory deficit, unsteady gait, bowel/bladder continence, and safety needs.</li> </ol> <p>Review of Patient 1's medical record reveals that she was a 99 year old female admitted to the facility on October 28, 2007 with diagnoses of right hip fracture, status post fall, right superior rami (pelvic) fracture, anemia and thrombocytopenia (decrease in platelets), and dementia.</p> <p>During an interview on December 26, 2007 at 10:35 AM, Staff B stated on December 15, 2007 at 12 PM that while picking up lunch trays, she saw Patient 1 "half on the mat with her head on the floor". Blood was noted on the floor and Patient 1's head was pointed towards the patio door on the opposite side of the room. Staff B paged the nurse to 106 and Staff C checked Patient 1. Staff B</p> |  | <p>Licensed Nursing personnel were in serviced on use of forms develop to ensure accurate evaluation of resident's cognitive status, bowel and bladder incontinence, and safety needs. The assessments of admits are done by the admitting Licensed Nurse and validated by Registered Nurses within 24/72 hours.</p> <p>A systematic change will be implemented for new admissions quarterly, annual and with significant changes of condition. In addition the mental status form, bowel and bladder assessment, and the fall risk assessment will be reviewed. The Director of Nurses will randomly validate accuracy of assessments of 20 percent of new admissions for the first 30 days and then 10 percent for the next 90 days. At that time The Director will re-evaluate the system for effectiveness.</p> | <p>2/03/2010</p> <p>2/03/2010</p> <p>12/03/2010</p> <p>2/03/2010</p> |
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Event ID: 4GH311      1/19/2010      9:07:07AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:  TITLE: Administrator (X6) DATE: 1/29/2010

Any ending with asterisk (i) notes a may be excused from it is determined that other safeguards provide sufficient protection on 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 cited, an approved plan of correction is requisite to continued program participation.

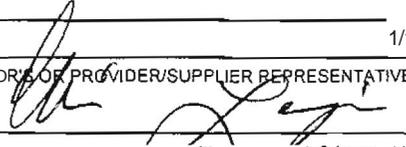
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|  | <p>Continued From page 2</p> <p>stated Patient 1 was bleeding and her head was cut above her eyebrow. When questioned, Patient 1 said her right arm and her hip were hurting. Staff B said, "She just didn't use the call light."</p> <p>On December 26, 2007 at 10:45 AM, during an interview, Staff C stated after the accident he checked her vitals signs and blood pressure which were fine. The resident was talking and complained of her right hip and her right arm hurting. Staff C noted her head was bleeding above her right eyebrow and put a pressure dressing on her head. Patient 1 was then transported via ambulance to a nearby acute hospital emergency room.</p> <p>On December 26, 2007 at 11 AM, a record review of the acute hospital medical record read, "Patient 1 was unconscious and nonverbal when assessed by the emergency room physician upon arrival" The CT Scan performed at 2:09 PM (2 hours after the fall) revealed a large acute onchronic right frontal parietal temporal subdural hematoma (clotted blood between the brain and the lining covering the brain on the right side) with mass affect and midline shift. A craniotomy (incision into the skull) was performed on December 15, 2007 for evacuation of the hematoma and insertion of a drain. Patient 1 never regained consciousness and subsequently expired on December 18, 2007 at 11:59 PM, three days after her fall.</p> <p>1. Patient 1's initial Fall Risk Assessment (undated) with a total of 12 points read she was alert (oriented x 3), chair bound, had vision and balance difficulties, and had previous falls and</p> |  | <p>Minimum Data Set Nurse reviews care plans during daily interdisciplinary meetings with the team so that all care plans are reviewed and updated quarterly for accuracy. Staff Developer will in service Licensed Staff on fall risk observation and change of conditions. Additionally, A Licensed Nurse Supervisor conducts shift to Shift report to inform direct care staff of residents who are at risk for potential falls. Direct care staff will be informed of Bowel and Bladder and cognitive status changes, The Administrator utilizes A Quality Assurance Tool to monitor findings of Director of Nurses weekly for one month then monthly for three months to ensure that admissions have been reviewed. Corrections are made at that time. Findings will be submitted by the Administrator to The Quality Assurance Committee monthly,</p> | <p>2/03/2010</p> <p>12/03/2010</p> <p>2/03/2010</p> |
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|   | <p>Continued From page 3</p> <p>fractures. The next Fall Risk Assessment form dated November 12, 2007 with a total of 12 points read she was alert (oriented x 3), ambulatory, had adequate vision, had gait and balance difficulties, and had previous falls and fractures. The Fall Risk Assessment form read "Upon admission and Quarterly (at a minimum) thereafter, assess the resident status in the eight clinical condition parameters listed below. . . . If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan."</p> <p>During an interview on December 26, 2007 at 1 PM, Staff A stated, "She was not on the Falling Star program (an identification method implementing stars for residents with high risk for falls, increased surveillance, and interdisciplinary planning for prevention of falls) because she had not fallen here before. She didn't want to get out of bed for physical Or occupational therapy. We have no side rails in our facility and we are restraint-free."</p> <p>During an interview and record review on December 29, 2007 at 12:15 PM, Patient 1's Care Plan titled, "Client Protection Plan for Safety", dated November 12, 2007 read to check patient every 2 hours and PRN (as needed) for safety. When documentation of 2 hour monitoring was requested, Staff B stated that there was no documentation of 2 hour monitoring and further commented, "I just know that we watch her real close. Thafs why she's in a bed by the door." Staff A was also unable to provide two hour monitoring documentation at this time.</p> |   |   |

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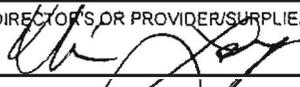
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|   | <p>Continued From page 4</p> <p>Resident 1's care plan titled "Safety/Fall" dated November 12, 2007 read: "Diagnosis: Dementia" and gave an approach plan as "soft mat on the floor to prevent injury from resident getting up unassisted" and "explain risks and benefits of using call light and waiting for assistance to prevent fall or injury". The care plan does not identify a plan for evaluating cognition deficit and memory problems.</p> <p>2. During a record review on December 29, 2007 at 12:15 PM, Patient 1's MDS dated November 26, 2007 documented memory recall problem and difficulty in making decisions in new situations. The interdisciplinary team review care plan conference dated November 12, 2007 indicated short term memory problems and read "May miss some part of message."</p> <p>Resident 1's care plan titled "Safety/Fall" dated November 12, 2007 read: "Diagnosis: Dementia" and gave an approach plan as "soft mat on the floor to prevent injury from patient getting up unassisted" and "explain risks and benefits of using call light and waiting for assistance to prevent fall or injury." The care plan does not identify a plan for evaluating cognition deficit and memory problems.</p> <p>Nurse's notes dated November 8, 15, 16, 18, and 24, 2007 read Patient 1 "goes to the bathroom."</p> <p>Nurse's notes dated November 22, 2007 read Patient 1 has "occasional episodes of confusion and disorientation." Resident Assessment Protocol (RAP Summary dated November 12, 2007 read Patient 1 was "able to walk from bed to bathroom and vice versa with one person for physical assistance."</p> |   |   |  |

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



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Administrative

(X6) DATE

1/29/2010

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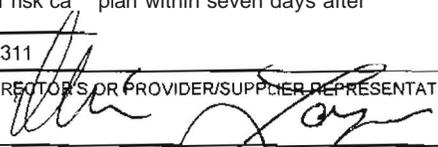
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|                    | <p>Continued From page 5</p> <p>During an interview on December 26, 2007 at 9:50 AM, Staff A stated that the incident was unusual for Patient 1 since "she never got out of bed." Patient 1's MDS dated November 26, 2007 read Patient 1 needs limited assistance with one person to transfer from bed to chair and Patient 1 spends 1/3 to 2/3 of her time involved in activities and prefers the activities room.</p> <p>During a record review on December 26, 2007 at 12:45 PM, a statement written by Staff B read "It is unusual for this resident to get up without help because she is alert and always asks for assistance or rings the call light when she wants help or to get out of the bed." However, the Care Plan titled "Safety Fall" dated November 12, 2007 read, "Resident has periods of non-compliance vs. non-cooperative to call"</p> <p>3. During a record review on December 29, 2007 at 12:15 PM, Patient 1's MDS dated November 26, 2007 read she was continent of both bowel and bladder. However, the Resident Assessment Protocol dated November 12, 2007 read "Resident is incontinent of both bowel and bladder." Nursing Assistant Daily Row Sheets for December 2007 read Patient 1 was continent of both bowel and bladder, had bathroom privileges, and needed extensive assistance to transfer.</p> <p>Therefore, based on interview, observation, and record review, the facility failed to:</p> <p>1. Accurately assess Patient 1 and implement a fall risk care plan within seven days after</p> |               |   |                    |

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|  | Continued From page 6 admission,<br><br>2. Accurately assess and implement care plans for Patient 1 which identifies memory deficits, bowel/bladder continence, and safety needs.<br><br>3. Review and update care plans for Patient 1 which identifies fall risk, memory deficit, unsteady gait, bowel/bladder continence, and safety needs.<br><br>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 was a direct proximate cause of the death of the patient. |   |   |  |

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