

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2008
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ESKATON CARE CENTER MANZANITA	STREET ADDRESS, CITY, STATE, ZIP CODE 5318 MANZANITA AVENUE, CARMICHAEL, CA 95608 SACRAMENTO COUNTY
--	---

(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>CLASS AA CITATION -- PATIENT CARE 03-1698-0007577-F Complaint(s): CA00174717, CA00160099, CA00160099, CA00157781</p> <p>Representing the Department of Public Health: [REDACTED]</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>F323 Free of Accident Hazards/supervision/devices 483.25(h) 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.</p> <p>During an unannounced visit on 08/13/08, the investigation of a facility reported event, #CA00157781, as well as Complaint # CA00160099 were initiated. In addition Complaint # CA00174717 was received and investigated along with the previous self report and complaint. As a result of the investigation, the Department determined the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure the environment is as free from accident hazards as possible. 2. Provide adequate supervision and assistive 			
--	--	--	--	--

Event ID: HDU911

9/27/2010

12:04:12PM

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: 555083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2008
NAME OF PROVIDER OR SUPPLIER ESKATON CARE CENTER MANZANITA		STREET ADDRESS, CITY, STATE, ZIP CODE 5318 MANZANITA AVENUE, CARMICHAEL, CA 95608 SACRAMENTO COUNTY		
(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>Continued From page 1</p> <p>devices to prevent accidents.</p> <p>On 09/25/08, Resident A's clinical record was reviewed. Resident A was a 60 year old female was re-admitted to the facility on 07/19/08 with diagnoses that included Myotonic dystrophy (an inherited disorder of the muscles and other body systems, characterized by progressive muscle wasting and weakness, particularly in the lower legs, hands, neck, and face), type II diabetes, and congestive heart failure. Resident A had been a resident at the facility for many years but was at a General Acute Care Hospital (GACH) from 07/12/08 - 07/19/08 for evaluation and treatment of chest pain. An advance directive from the previous admission dated 06/28/08 indicated Resident A had requested full resuscitation in the event of a cardio-respiratory arrest.</p> <p>Physician's Orders dated 07/19/08 documented that Resident A had decision making capacity and had been informed of her condition. A 07/19/08 order also directed staff to get Resident A out of bed twice a day. Transfers between bed and chair were done using a mechanical lifting device.</p> <p>A Resident Progress Note by an RN (Registered Nurse) documented that at about 8:00 p.m. on 07/20/08, CNA (Certified Nursing Assistant) 1 and CNA 2 were using A mechanical lift to transfer Resident A from the wheelchair to the bed. While the CNAs were moving the lift device, the sling broke. Resident A fell to the floor hitting the left side of her head on the adjacent door. The facility called the patient's husband and 911. At about 8:25 p.m. Resident A was transferred to a GACH Emergency Room (ER).</p>			

Event ID: HDU911

9/27/2010

12:04:12PM

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: 555083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/29/2008
NAME OF PROVIDER OR SUPPLIER ESKATON CARE CENTER MANZANITA			STREET ADDRESS, CITY, STATE, ZIP CODE 5318 MANZANITA AVENUE, CARMICHAEL, CA 95608 SACRAMENTO COUNTY		
(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>Continued From page 2</p> <p>On 09/25/08 at 1:55 p.m. the facility Maintenance Director was interviewed. The maintenance logs for the lifts were requested. The Maintenance Director stated he did not have any documentation of routine maintenance or safety checks on the lifts. He stated that the lift involved in the incident with Resident A on 07/20/08 was approximately five years old. He stated no maintenance had been performed on this lift. The Maintenance Director stated that "the lift mechanism itself did not fail", "the sling had torn." He stated at the time of the incident he "did not have any mechanisms/procedures in place for the repair or replacement of slings."</p> <p>The manual titled {Brand Name} Lift Owners Manual was provided by the Maintenance Director and reviewed. The manufacturer's manual documented that "slings should be checked initially and every month." This manual also had the warning "Bleached, torn, cut, frayed or broken slings are unsafe and could result in injury."</p> <p>In a visit to the GACH on 10/06/08 Resident A's medical record was reviewed. An Emergency Room Admission Report dated 07/20/08 documented Resident A was mumbling and confused and having respiratory distress when she arrived. After a CAT (computerized axial tomography - a radiological procedure similar to an x-ray) Scan of the head was done, the ER physician documented that Resident A was transferred to the intensive Care Unit (ICU) with a diagnosis of "Subdural hematoma (bleeding from an injury to the area between the skull and the</p>				

Event ID: HDU911

9/27/2010

12:04:12PM

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: 555083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/29/2008
NAME OF PROVIDER OR SUPPLIER ESKATON CARE CENTER MANZANITA			STREET ADDRESS, CITY, STATE, ZIP CODE 5318 MANZANITA AVENUE, CARMICHAEL, CA 95608 SACRAMENTO COUNTY		
(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>Continued From page 3</p> <p>brain, which results in serious brain damage related to increased pressure), status post fall."</p> <p>At the GACH, a 07/21/08 Consultant Report by the neurologist documented that Resident A had her eyes open but did not follow commands or respond. The neurologist documented that Resident A had a subdural/subarachnoid hemorrhage (bleeding on the surface of the brain and into the brain causing pressure on brain tissue with resulting brain damage) which had grown and evolved since the day before. The neurologist also documented "At this point I do not see any role for neurosurgical intervention." On 07/22/08 Resident A was going to be transferred to the neurology unit at another GACH when she suffered a seizure. A CT Scan of the head was repeated and was stable so Resident A was transferred to the second GACH.</p> <p>On 10/07/08 the second GACH was visited and the medical record was reviewed. At the second GACH, Resident A's condition was rated "poor" on admission. Because of the injury and her other conditions the family was consulted and told she would likely not survive surgery to relieve the pressure and stop the bleeding. The patient was placed on comfort measures. On 07/24/08 at 9:10 a.m. Resident A expired. On the Death Note, the attending physician listed the cause of death as "L (left) acute subdural hematoma, due to trauma/fall."</p> <p>Review of the 12/23/08 Sacramento County Coroner Final Report of Investigation, read that the Cause of Death was blunt head trauma. Description of how the injury occurred stated "Decedent fell when the</p>				

Event ID: HDU911

9/27/2010

12:04:12PM

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: 555083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/29/2008
NAME OF PROVIDER OR SUPPLIER ESKATON CARE CENTER MANZANITA			STREET ADDRESS, CITY, STATE, ZIP CODE 5318 MANZANITA AVENUE, CARMICHAEL, CA 95608 SACRAMENTO COUNTY		
(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>Continued From page 4</p> <p>Hoyer lift at her nursing home broke". A full autopsy was done and the "Autopsy Findings" were "... left parietal subdural hematoma without mass effect, focal left frontal subarachnoid hemorrhage with associated hemorrhagic necrosis of the underlying cortex..."</p> <p>On 10/09/08, Resident A's husband was interviewed. He stated that, on the evening of 07/20/08, he had just returned home when he received a phone call requesting that he return to the facility. He stated that at the time of the first visit his wife had been alert and sitting up in her wheelchair. He stated that when he came back after the accident his wife was conscious but could not speak to him. He stated he was told by paramedics that her head had hit the floor and that her left pupil was dilated.</p> <p>On 10/29/08 at 8:10 a.m., a visit was made to the facility corporate office where the torn sling was kept. The corporate Safety Manager identified a sling as the one that had been used with Resident A on 07/20/08. The sling appeared worn with what appeared to be bleached out blood stains at the center. Both support straps at the foot end of the sling were torn off. The strap at the top which would have been on the patient's left side had begun to tear where the strap was sewn to the sling.</p> <p>A second visit was made to the facility on 10/29/08 at 8:30 a.m. The Maintenance/Laundry Supervisor stated that the facility had no instructions or procedures for laundering the lift sling.</p>				

Event ID: HDU911

9/27/2010

12:04:12PM

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: 555083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2008
NAME OF PROVIDER OR SUPPLIER ESKATON CARE CENTER MANZANITA		STREET ADDRESS, CITY, STATE, ZIP CODE 5318 MANZANITA AVENUE, CARMICHAEL, CA 95608 SACRAMENTO COUNTY		
(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>Continued From page 5</p> <p>On 10/29/08 at 12:15 p.m. one of the CNAs involved in the accident was interviewed by telephone. CNA 2 stated she had come into Resident A's room on 07/21/08 in the evening to help CNA 1 get Resident A back to bed from the wheelchair. CNA 2 stated that Resident A had been sitting on the sling in the wheelchair. CNA 2 stated she had been at the patient's head and CNA 1 had been at the feet. She stated that when CNA 1 started to pump up the lift, Resident A seemed like she shifted her weight. Next CNA 2 heard a pop and Resident A began falling. She stated that the patient had been closer to the door than the bed when the lift was used. As a result, when the sling tore Resident A fell hitting her head on the door.</p> <p>The facility failed to ensure that assistance devices used in patient care were checked and maintained in accordance with manufacturers' recommendations and in a manner to prevent injury to the patient. This resulted in Resident A's fall, head injury and death.</p> <p>As a result of the investigation, the Department determined the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure the environment is as free from accident hazards as possible. 2. Provide adequate supervision and assistive devices to prevent accidents. <p>These violations presented either (1) imminent danger that death or serious harm to the patients or</p>			

Event ID: HDU911

9/27/2010

12:04:12PM

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: 555083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2008
NAME OF PROVIDER OR SUPPLIER ESKATON CARE CENTER MANZANITA		STREET ADDRESS, CITY, STATE, ZIP CODE 5318 MANZANITA AVENUE, CARMICHAEL, CA 95608 SACRAMENTO COUNTY		
(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
2	<p>Continued From page 6</p> <p>residents of the long-term health care facility would result therefrom, or (2) substantial probability that death or serious physical harm to patients or residents of the long-term health care facility would result therefrom and were a direct proximate cause of death of the patient or resident.</p>			

Event ID: HDU911

9/27/2010

12:04:12PM

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.