

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555459</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/01/2008</b>
NAME OF PROVIDER OR SUPPLIER <b>GRAMERCY COURT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 GRAMERCY DRIVE, SACRAMENTO, CA 95825 SACRAMENTO COUNTY</b>		
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	<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:  <span style="background-color: black; color: black;">XXXXXXXXXX</span> HFEN</p> <p>CLASS AA CITATION -- PATIENT CARE 03-1662-0005091-S Complaint(s): CA00086645</p> <p>72311. Nursing Service - General (a) Nursing service shall include, but not be limited to the following: (1) Planning of patient care, which shall include at least the following: (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 assessment shall commence at the time of admission of the patient and be completed within seven days after admission. (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 patient's condition. (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>72315. Nursing Service - Patient Care (h) Each patient shall be provided with good nutrition and with necessary fluids for hydration.</p>			

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	<p><b>Continued From page 1</b></p> <p>72523 Patient Care Policies and Procedures. (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>Unannounced visits were made to the facility on 12/30/06, 01/11/07, 01/16/07, 03/14/07 and 07/02/07 to investigate complaint #CA00086645 regarding quality of care/treatment.</p> <p>The Department determined the facility failed to:</p> <ol style="list-style-type: none"> <li>1) continually assess Patient A's hydration needs</li> <li>2) implement/update a care plan for hydration</li> <li>3) provide the necessary fluids for Patient A's hydration needs to help prevent a urinary tract infection and dehydration and</li> <li>4) implement their policy regarding care planning.</li> </ol> <p>These failures resulted in Patients A becoming dehydrated, developing a urinary tract infection and being transferred to a general acute care hospital (GACH) on 06/20/06 where upon admission to the Emergency Room Patient A's sodium level was 165, BUN (blood urea nitrogen) was 145 and creatinine was 4.6. Patient A's GACH "History and Physical" dated 06/20/06, revealed Patient A was admitted with "dehydration and uropsepsis (generalized infection related to an infection of the urinary tract)." Patient A died on 06/22/06. According to the "Expiration Summary" the cause</p>				

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	<p><b>Continued From page 2</b></p> <p>of death was septicemia &amp; renal failure."</p> <p>Patient A, a 73 year-old female, was originally admitted to the facility on 10/05/00. She had the following diagnoses: generalized weakness, osteoporosis, cataracts, dementia without behavioral disturbances and peripheral neuropathy.</p> <p>Patient A's Annual Minimum Data Set (MDS, a standardized assessment tool), dated 02/10/06, documented "Dehydration/Fluid Maintenance" triggered in the 02/15/06 RAP (Patient Assessment Protocol) problem area and the column, "Care Planning Decision-check if addressed in care plan," was checked, indicating dehydration/fluid maintenance was to be addressed in a care plan. According to the RAP Progress Notes, dated 02/13/06, dehydration triggered "due to use of lasix, a medication that facilitates removal of free water from the blood stream via the urinary system)."</p> <p>The MDS, under "Section V. Patient Assessment Protocol (RAP) Summary," revealed the following: "For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problems(s) identified in your assessment. The Care Planning Decision column must be complete within 7 days of completing the RAI (MDS and RAPS)."</p> <p>Review of a facility policy titled, "Minimum Data Set (MDS)," undated, under the section, "Care Planning:" revealed, "Each discipline will be responsible for implementing a written Care Plan for</p>			

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	<p><b>Continued From page 3</b></p> <p>the problem/concern identified. Under the section, "Overall Responsibilities of the MDS Coordinator Related to the RAI Process:" documented, "Coordinate/delegate care planning documentation tasks as needed to assure care plans are current."</p> <p>Patient A's clinical record contained a care plan for "Risk for weight loss/DHN (dehydration) related to:" obesity, history of alcohol abuse, several missing upper and lower teeth." The care plan was originally dated 10/06/00 and at the top of the page was handwritten, "Recopied 09/29/05." Patient A's clinical record also contained a "Short Term Problem Care Plan," dated 03/23/06, for "Actual wt loss -8.5 #s R/T (related to) poor intake/diuresis" and "Risk: continued wt loss/DHN (dehydration)," 6 months later.</p> <p>During an interview with the Administrator 1 on 03/14/07 at 9:40 a.m. when asked what "Recopied 09/29/05" meant, at the top of Patient A's care plan for "Risk for weight loss/DHN (dehydration) related to:," she replied she didn't know but would ask Licensed Vocation Nurse (LVN) 2, who has been employed at the facility for 14 years. According to LVN 2 "Recopied 09/29/05" meant that the care plan was recopied on the written date and was the most current care plan. The section, "Approaches," included requirements to monitor hydration status of skin turgor and mucous membranes, notify MD of any abnormality, encourage frequent fluids and assist as needed.</p> <p>There was no care plan developed related to the use of diuretics regarding Patient A's triggered area</p>			

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	<p><b>Continued From page 4</b></p> <p>of "Dehydration/Fluid Maintenance," per their policy, "Minimum Data Set (MDS)</p> <p>Review of the facility's "Care Plan" policy, dated 03/06/04, documented "Care Plans are reviewed and revised by the IDT (Interdisciplinary Team) at quarterly conferences." There was no documentation Patient A's care plan for "Risk for weight loss/DHN (dehydration)" was reviewed and revised quarterly, per the facility's policy.</p> <p>Patient A's Quarterly MDS dated 04/24/06, documented her as having short and long-term memory problems, and as having moderately impaired cognitive skills for daily decision making She was sometimes able to make herself understood and was usually able to understand others. The MDS described Patient A as needing extensive assistance with bed mobility and personal hygiene, as being totally dependent upon staff for transfers, locomotion on and off the unit, dressing and toilet use, as needing supervision with eating and no weight change in the last 30 days. According to Patient A's Annual MDS, dated 02/10/06, Patient A was 65 in. Review of Patient A's "Weight Loss/Gain Log" revealed on 04/24/06 Patient A weighed 156.9 lbs.</p> <p>Review of Patient A's clinical record revealed a form titled, "Gramercy Court Advance Directive" signed and dated by Patient A on "6/11/3" and signed and dated by the physician on "10/8/5." The form documented Patient A was to receive "No CPR (cardiopulmonary resuscitation) and no artificial nutrition (tube feeding) but was to receive IV</p>				

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	<p><b>Continued From page 5</b></p> <p>(intravenous) fluids/hydration and transfer to the acute care if needed."</p> <p>Patient A's Physician's Orders, for the month of June 2006, revealed Patient A was taking Lasix 20 mg PO (by mouth) every day and Aldactone 50 mgm Po every day (used to treat certain patients with edema (fluid retention) caused by various conditions. It causes the kidneys to eliminate unneeded water and sodium from the body into the urine, but reduces the loss of potassium from the body). According to a fax sent to Patient A's physician on 05/17/06 Patient A was prescribed these two medications due to bilateral lower extremity edema.</p> <p>Review of Patient A's, "Interdisciplinary Patient Care Conference," dated 04/25/06, with a check mark next to the word, "Quarterly," revealed under the section, "Assessment" a check mark in the box, "Yes" next to the word, "Hydration." Review of the facility's "Hydration" policy, undated, documented, "Each Patient's hydration status will be assessed by the IDT ...quarterly." "Patients who are identified "at risk for dehydration" will be care planned, goals established, and interventions determined."</p> <p>Review of Patient A's clinical record revealed no documentation of a hydration assessment. During an interview with Administrator 3 and Director of Nurses 4 on 07/16/07 at 8:40 a.m., they confirmed there was no hydration assessment completed during the IDT conference on 4/25/06 in Patient A's clinical record.</p>			
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	<p><b>Continued From page 6</b></p> <p>From 3/29/06 to 4/28/06 Patient A developed chewing and swallowing problems. The physician was notified and the diet was changed to mechanical soft at first and then to a pureed diet which she reportedly tolerated well.</p> <p>On 06/13/06 at 8:00 a.m., a fax was sent to Patient A's physician regarding Patient A having a "13.6 lbs wt loss in 1 month." On 06/14/06 an order was received for Patient A to be weighed weekly and to receive Med Pass (a supplemental drink that provides additional calories and protein) 4 oz. three times a day with documentation of percentage taken.</p> <p>Facility staff documented on the Medication Records the percentage of the Med Pass consumed by Patient A. There were 19 opportunities from 06/14/06 to 06/20/06. The records for percentage of Med Pass taken revealed the following:</p> <ul style="list-style-type: none"> <li>* 2 of 19 (10%) opportunities - no percentage recorded.</li> <li>* 1 of 19 (5%) opportunities - consumed 50% of Med Pass.</li> <li>* 16 of 19 (84%) opportunities - consumed 100% of Med Pass.</li> </ul> <p>Review of a "Nurses' Progress Note" (weekly summary), dated 06/07/06, for the "time period 05/30/06 thru 06/07/06," Patient A was described as needing "limited assist" with eating with "set-up only." The nurse documented Patient A as being</p>				

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	<p><b>Continued From page 7</b></p> <p>"only able to swallow pureed food." The licensed nurse also documented Patient A as having gained "2.3 lbs.", consuming an average of 75% of her food, as able to feed herself and Patient A's hydration status was described as "good."</p> <p>Review of a "Nurses' Progress Note," dated 06/12/06, for the "time period 06/07/06 thru 06/12/06," Patient A was described as needing "limited assist" with eating with "set-up only." The nurse documented Patient A as having swallowing problems and was on a pureed diet. The licensed nurse also documented Patient A as having lost 13.6 lbs., consuming an average of 60% of her food and Patient A's hydration status was described as "good."</p> <p>Review of a fax sent to Patient A's physician, dated 06/19/06 (with no time), revealed Patient A had an emesis. The licensed nurse requested an order for a clear liquid diet for 1 week. On 06/19/06 an order was received to change Patient A's diet to clear liquids for 1 week.</p> <p>Facility staff documented on the Medication Records the percentage of each meal consumed by Patient A. There were 78 opportunities (meals) from 05/25/06 to 06/21/06. The records for percentage of meal intake revealed the following:</p> <ul style="list-style-type: none"> <li>* 2 of 78 (2%) opportunities - no meal percentage recorded.</li> <li>* 9 of 78 (12%) opportunities - consumed less than 25% of meal.</li> <li>* 18 of 78 (23%) opportunities - consumed 26% to</li> </ul>				

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	<p><b>Continued From page 8</b></p> <p>50% of meal. * 13 of 78 (17%) opportunities - consumed 51% to 75 % of meal. * 36 of 78 (46%) opportunities - consumed 76% to 100% of meal.</p> <p>The above data reflected that 29 of 78 (37%) of the recorded opportunities Patient A consumed 50% or less of her meals.</p> <p>The estimated minimum amount of fluid required for this resident at 144.8 lbs on 06/13 was approximately 1950cc/24hours. The daily recorded fluid intake for the patient based upon the % of Med Pass and % of diet consumed for six days prior to discharge is summarized below.</p> <p>06/14 - 790cc 06/15 - 900cc 06/16 - 1464cc 06/17 - 972cc 06/18 - 762cc 06/19 - 660cc</p> <p>Direct care staff was interviewed on 01/16/07. Two CNA staff indicated Patient A would take fluids but needed assistance or encouragement.</p> <p>Patient A's daughter was interviewed, via telephone, on 07/12/07 at 10:00 a.m. She stated she visited Patient A "at least once a week." When asked if she visited Patient A during meal times she confirmed she did. The daughter also stated Patient A needed her meal tray to be set up. She stated Patient A was able to feed her self but would "lose</p>			

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	<p><b>Continued From page 9</b></p> <p>interest" and needed to be "prompted to eat and take fluids."</p> <p>There was no documented evidence that the facility revised the plan of care and encouraged the Patient to take sufficient fluids to prevent dehydration (a risk factor for the development of urinary tract infection) when her meal intake declined in June. There is no evidence or care plan that the facility identified the patient as being at risk for urinary tract infection.</p> <p>Review of a Nurses Progress Note, dated 06/20/06 at 9:00 a.m. the licensed nurse documented Patient A as having increased respirations "@44. Skin cool, clammy (sic), pale....[sign for decrease] wt. (weight) @ 22 # (lbs) in past 2 wks. Pt. (patient) alert, non-verbal." The Nurses Progress Note revealed Patient A's physician was notified and an order was received on 06/20/06 at 9:00 a.m. to transfer Patient A to the GACH for an evaluation and treatment.</p> <p>Review of a form titled, "Patient Care Report (ambulance report), dated 06/20/06, revealed "staff states about 2 weeks ago pt (patient) began acting different and progressively became worse. Pt normally talks, non-verbal."</p> <p>The Discharge Summary from the skilled nursing facility for the 06/20/06 discharge indicated that the discharge diagnoses were "uropsepsis, dehydration and acute and chronic renal failure." The condition upon discharge was documented to be "poor." The Summary of Skilled Nursing Facility Course of Prior</p>				

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DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555459</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/01/2008</b>
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	<p><b>Continued From page 10</b></p> <p>Treatment documented that Patient A had a "Slow mental decline, slow progression of renal insufficiency, then developed a urinary tract infection and declined rapidly."</p> <p>Upon arrival to the Emergency Department (ED) on 06/20/06 (no time) Patient A's vital signs were the following: blood pressure - 83/50 (Low - Normal range for this patient was 120-130/70-80), pulse - 98, respirations - 16 and temperature - 101.2. Under the section "Chief Complaint" revealed "2 wk (weeks) of progressive ALOC (altered level of consciousness), [sign for decrease] appetite [sign for with] 20 lb wt (weight) loss over 1 mth (month)."</p> <p>Labs were obtained at the time of admission to the Emergency Department (06/20/06 at 10:45 a.m.). These labs were compared to the lab values taken while at the facility. Comparison of lab values revealed elevated changes in serum sodium level, creatinine and blood urea nitrogen (BUN) levels indicative of dehydration.</p> <p>Normal Reference Range Sodium 135-145 mmol/L BUN 9-28 mg/dL Creatinine 0.5-1.2 mg/dL</p> <p>Lab results of 04/19/06 (Facility) Sodium 132 BUN 26 Creatinine 1.9</p> <p>Lab results of 05/25/06 (Facility) Sodium 141</p>				

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	<p><b>Continued From page 11</b></p> <p>BUN           24 Creatinine   1.6</p> <p>Lab results of 06/20/06 10:45 a.m. (ED) Sodium       165 BUN           45 Creatinine   4.6</p> <p>According to the Merck Manual of Geriatrics Second Edition, published in 1995 "volume depletion (a loss of body water and sodium, resulting in decreased extracellular fluid volume) and dehydration (pure depletion of water alone) may present in several ways, but altered mental status, lethargy, light-headedness, and syncope are particularly common in elderly patients." "Hypernatremia (a greater than normal concentration of sodium in the blood) in the elderly poses a high risk of morbidity and mortality; often, the more severe the predisposing factor, the higher the risk. In one study of elderly hospitalized patients who developed hypernatremia with serum sodium levels &gt; 148 mEq/L, the mortality rate was about 40%. The mortality rate was highest in those with rapid onset and those with a serum sodium level of &gt; 160 mEq/L." "The clinical signs are those of volume depletion and dehydration-weight loss, decreased skin turgor, dry mucous membranes, and orthostatic hypotension. Besides an increased serum sodium level, the laboratory findings are those of hemoconcentration - increased hematocrit, serum osmolality, BUN and creatinine values."</p> <p>Review of Patient A's GACH "History and Physical (H&amp;P)," with a date of admission of 06/20/06,</p>				

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	<p><b>Continued From page 12</b></p> <p>revealed Patient A was admitted with "dehydration and uropsepsis..." The H&amp;P further revealed "apparently two weeks ago she (Patient A) began to eat less and lose weight." Under the section, "Physical Examination," Patient A was described to have "pink and dry" mucous membranes.</p> <p>According to the GACH "Record of Death and Disposition" Patient A expired on 06/22/06.</p> <p>Review of Patient A's GACH "Expiration Summary" documented Patient A was "admitted with acute pyelonephritis and dehydration, acute superimposed and chronic renal failure." The summary further documented "She (Patient A) is quite hypernatremic to 165 on admission, and she was given hypotonic fluids." According to the summary, the "Cause of Death" was Septicemia (systemic infection in which pathogens are present in the circulating bloodstream, having spread from an infection in any part of the body, also called blood poisoning) and renal failure.</p> <p>The death certificate listed acute renal failure as a primary cause of death and urinary tract infection as a secondary cause of death.</p> <p>Therefore, the facility failed to:</p> <ol style="list-style-type: none"> <li>1) continually assess Patient A's hydration needs</li> <li>2) implement/update a care plan for hydration</li> <li>3) provide the necessary fluids for Patient A's</li> </ol>				

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	<p><b>Continued From page 13</b></p> <p>hydration needs to help prevent a urinary tract infection and dehydration and</p> <p>4) implement their policy regarding care planning.</p> <p>The failures resulted in Patient A becoming severely dehydrated, developing a urinary tract infection with uropsepsis (generalized systemic infection), resulting in acute renal failure and death.</p> <p>The above violations present either (1) imminent danger that death or serious harm to the patients or 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 the patient's death.</p>				

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