

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>06/12/2008</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>CLASS AA CITATION -- PATIENT CARE 03-1255-0007455-F Complaint(s): CA00130836</p> <p>Representing the Department of Public Health: [REDACTED], HFES</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>F 3 2 3 F r e e o f A c c i d e n t 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>Unannounced visits were made to the facility beginning on 11/9/07 to investigate complaint #CA00130836 regarding Resident A's fall.</p> <p>At the completion of the inspections, the Department determined that the facility failed to:</p> <ol style="list-style-type: none"> <li>1) Ensure that each resident receives adequate supervision.</li> <li>2) Ensure that the resident receives assistance devices to prevent accidents.</li> </ol>			

Event ID: YLEB11

8/3/2010

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	<p><b>Continued From page 1</b></p> <p>These violations resulted in Resident A falling from her bed to the floor on 10/12/07 when CNA 1 turned her back to the resident to check the position of the wheelchair while the side rail was in the down position and the resident was without the support and protection of the side rail and the supervision of the CNA. As a result Resident A fell to the floor and required emergency transfer to the General Acute Care Hospital (GACH) for evaluation and treatment. While at the GACH Resident A had x-rays and scans demonstrating "a fracture of C1 and C2 (first and second cervical spine or neck bones)." Resident A was admitted for treatment and subsequently died on 10/16/07 as a direct result of the trauma.</p> <p>A review of Resident A's medical record at the facility revealed she was a 97 year old, originally admitted to the facility on 1/31/07 and re-admitted on 8/11/07 with multiple diagnoses including recent stroke and dementia. The Admission Minimum Data Set (MDS, an assessment tool) with the reference date of 2/6/07 noted that Resident A was 5' 7" tall and weighed 104 pounds.</p> <p>The Activities of Daily Living (ADL) care plan dated 8/11/07 included that Resident A "Requires assistance in Ambulation... Transfers... Personal hygiene... Locomotion, Bed mobility." Related diagnoses documented on the care plan included Dementia/□Cognition." The "Injury</p>				

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	<p><b>Continued From page 2</b></p> <p>Care Plan: initiated on 8/11/07 identified the resident as having the "Potential" for injuries related to limited mobility and a diagnosis of "Dementia." Goals included the resident "Will be free from injury q (each) shift" and "Will be free from falls."</p> <p>The MDS quarterly review with the reference date of 8/15/07 documented Resident A as having moderately impaired cognition, short and long term memory deficit, was sometimes understood, sometimes understood others and had repetitive physical movements. She required extensive assistance with bed mobility and was totally dependent on staff for transfers, dressing and personal hygiene. The MDS further noted Resident A had functional limitations in her range of motion and partial loss of voluntary movement on the left side that affected her left hand (including wrist or fingers) and her left leg (including hip or knee). Resident A had flexion contractures of both lower extremities, the right more bent than the left.</p> <p>Physician's Orders dated 09/04/07 included an order for "side rails for mobility and lap buddy (a plastic foam restraint used while in a chair) for positional support." Resident A was not able to sit upright unassisted or without support.</p> <p>According to the Nurse's Notes dated 10/12/07 at 7:00 a.m., Resident A "Fell from bed on floor during ADL care. CNA (Certified Nurse</p>				

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	<p><b>Continued From page 3</b></p> <p>Assistant) was attempting to adjust w/c (wheel chair) and transfer resident when she had a fall c (with) injury." The injuries documented within the Nurse's Notes included a 2 cm (centimeter-one inch = 2.5 cm) by 3 cm (approximately 0.8 in x1 in) laceration to the right elbow and a 5 cm by 4 cm (approx 2 in x 1.5 in) laceration to the resident's forehead. At 7:35 a.m., Resident A was transported by emergency medical staff to the GACH for further evaluation.</p> <p>The facility report of the incident documented Resident A's bed was in the high position when the fall occurred.</p> <p>According to the GACH's Emergency Department Report dated 10/12/07 for Resident A, "The resident had a CT (CAT scan) of the neck which shows multiple fractures...There is also a fracture of C1 and C2 (first and second cervical spine or neck bones)." It was noted that she complained of a headache. The head lacerations required suturing. Resident A was deemed not to be a surgical candidate and was admitted for support and conservative treatment.</p> <p>The Emergency Department Note documented that Resident A had a complex unstable fracture of both cervical vertebra (C1 and C2). "There is a type III density fracture (a fracture through the base of the odontoid process, a bony prominence that stabilizes the upper cervical spine) that necessitated keeping her lying on her back with a rigid cervical-spine</p>				

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	<p><b>Continued From page 5</b></p> <p>neurological compromise." She expired on 10/16/07 at 8:30 p.m.</p> <p>The GACH's Expiration Summary dictated 10/16/07 noted Resident A as having "suffered a C1-C2 fracture" and "was not a surgical candidate." Resident A "Continued to be nonresponsive" and was pronounced at 8:30 p.m.</p> <p>According to the County Coroner Final Report of Investigation, Resident A's date of death was 10/16/07. The cause of death was "Blunt force injuries of head and neck." Under "Injury Information" the document included "Decedent fell from hospital bed to floor."</p> <p>During an interview with DON 1 on 11/9/07 at 9:50 a.m., he stated that following the facility's investigation of Resident A's fall, it was felt that the fall was "An accident." According to Administrator 1 who was interviewed on 11/9/07 at 12:15 p.m., CNA 1 did not have a current performance evaluation and that the facility was in the process of "Catching up."</p> <p>On 5/1/08 at 9:50 a.m., a telephone interview was conducted with CNA 1. According to the CNA, she was attempting to transfer Resident A to the wheelchair just prior to the fall. The resident was in the "Middle of the bed on her back with her right leg bent in the air." CNA 1 "turned for a split second to check the wheelchair to make sure it was in position" and "Resident A rolled to her left side and onto the</p>			

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	<p><b>Continued From page 6</b></p> <p>floor." The CNA concluded with "It happened real fast."</p> <p>On 5/17/08 at 1:45 p.m., CNA 1 was interviewed while at the facility. She stated on the day of the fall, the right side of Resident A's bed was against the wall which was its normal position. After she finished washing and dressing Resident A, the CNA was ready to transfer her from the bed to the wheelchair. The resident's wheelchair was in the opened/unfolded position next to the foot of the bed, facing forward and to her left as she faced Resident A. The wheelchair's wheels were locked. CNA 1 again stated Resident A was lying on her back "in the middle of the bed with the side rails (bed rails) up." When CNA 1 was ready to transfer the resident from the bed to the wheelchair, she lowered the left bed rail and turned to her left toward the foot of the bed to "double check" the position of the wheelchair located next to the foot of the bed. The CNA then stated that "Out of the corner of my eye" she saw Resident A "Turn and fall" from the bed, but was too late to stop her fall to the floor. Resident A landed face down. The resident's left bed rail was in the down position as CNA 1 was at the foot of the bed checking the wheelchair.</p> <p>During a follow-up interview with CNA 1 on 6/12/08 at approximately 2:00 p.m., she stated Resident A did not have a standard mattress or sheets, but had an "Air mattress" at the time of the fall that was "a little slippery" and the bed</p>			

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	<p><b>Continued From page 7</b></p> <p>had large bed rails. She also indicated that the head of the bed was not elevated; the bed was in a flat position,</p> <p>On 6/12/08 at 12:50, DON 2 was interviewed. She was asked if there were corrective actions in place related to Resident A's fall. The DON stated that in-service training was given to the licensed nurses related to not moving injured residents, however there were no corrective actions or in-service training provided to CNA 1 since the accident "Was not her fault."</p> <p>According to CNA 1's personnel file that was reviewed on 6/12/08, she was hired by the facility on 8/7/06. A review of CNA 1's in-service training records revealed the following:</p> <p>The "Inservice Attendance Record" within the file included multiple subjects including, "Accident Prevention and Safety Measures." The areas on the form for "# OF HOURS" attended; "TIME" and the "SIGNATURE/TITLE" were blank.</p> <p>The "INSERVICE/CONTINUING EDUCATION PROFILE INDIVIDUAL COURSE ATTENDANCE RECORD" included multiple program titles, including under item 15, "Accident Prevention/Safety," and on the reverse of the form, "Fall Prevention." The areas on the form for "INSTRUCTOR NAME/TITLE", "TIME STARTED/END", and the "DATE" were blank.</p>				

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	<p><b>Continued From page 8</b></p> <p>As of 6/12/08, there was no documented evidence that CNA 1 received in-service training for "Accident Prevention" and "Safety" since her date of hire of 8/7/06, more than two years later.</p> <p>Family was interviewed on 07/09/10. The family member stated, "The facility told us that they were transferring my mother from the bed to the chair, the nurse let go if her and she fell. There was only one nursing assistant with her at the time. I did not ever see her move or turn herself. She sometimes got her arms caught in the rails."</p> <p>The Son further stated, "When she got to the hospital, she was as responsive as she ever was. She just seemed like she wanted to go to sleep."</p> <p>The GACH's Expiration Summary dictated 10/16/07 noted "Continued to be nonresponsive" and was pronounced dead at 8:30 p.m.</p> <p>Resident A was left unattended without the side-rail in place or staff presence to prevent her from falling from the bed (which was in the high position) to the floor. She sustained critical injuries and as a result of the fall, she died.</p> <p>These failures which led to Resident A's fall from bed violated regulatory requirements and the failure to provide the assistance of the side</p>			

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