

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

*Doc. accepted
K. Hwang 12/29/11*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2011
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NAME OF PROVIDER OR SUPPLIER MOTION PICTURE & TELEVISION HOSPITAL D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 23388 MULHOLLAND DR., WOODLAND HILLS, CA 91364 LOS ANGELES COUNTY
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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 93-2354-0008531-F Complaint(s): CA00246798</p> <p>Representing the Department of Public Health: Surveyor ID # 28186, HFEN</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>42 CFR §483.25(h) Accidents.</p> <p>The facility must ensure that –</p> <p>(1) The resident environment remains as free from accident hazards as is possible; and</p> <p>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>On November 30, 2010 at 8:15 a.m., an unannounced visit was made to the facility to investigate the incident of Resident 1's fall down a flight of stairs while in her wheelchair.</p> <p>Based on record reviews and interviews, the facility failed to provide a safe environment and adequate supervision to Resident 1, who had dementia with history of falls, from exiting the door to a flight of the stairs. Resident 1 had previously fallen down the same flight of stairs in [REDACTED] 2007 without injuries. On [REDACTED] 2010, Resident 1 wheeled herself out the second floor through the</p>		<p>The provider submits this response and Plan of Correction as part of the requirements under the State and Federal Law. The Plan of Correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors, or shareholders.</p> <p>The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party.</p> <p>• The corrective action was accomplished for the resident(s) affected by the deficient practice:</p> <p>-Door alarm installed on Two West exit door to stairwell</p> <p>-Security rounds instituted every two hours, checking doors to stairwells, patency of alarms and closure of fire doors</p>	<p>10/22/10</p> <p>10/22/10</p>
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Event ID:06KL11

12/29/2011

8:50:59AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Susan Chubb</i>	TITLE VP, PROFESSIONAL SERVICES	(X6) DATE 12/29/11
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	<p>Continued From page 1</p> <p>West exit door to the stairwell. Resident 1 fell out of the wheelchair between the first and second floors and sustained a burst fracture (a vertebra, spine bone, is crushed in all directions) of her neck and a severe lumbar fracture. Surgery was not medically recommended, and subsequently, the resident expired seven days later on [REDACTED], 2010. According to the death certificate, the immediate cause of death was "sequelae of fall."</p> <p>On November 30, 2010 at 10:45 a.m., a review of Resident 1's face sheet record indicated the resident was a [REDACTED] year old female who was admitted to the facility on [REDACTED] 2009 with admitting diagnosis of status post upper gastrointestinal bleeding. The History and Physical dictated on [REDACTED] 2010, indicated the resident was assessed with Alzheimer type dementia with behaviors of agitation and aggression.</p> <p>The Minimum Data Set (MDS), full assessment and care screening tool, dated [REDACTED] 2010, indicated the resident had short and long-term memory problems, poor safety awareness, and moderately impaired cognitive skills for daily decision-making that required cues/supervision. The MDS indicated the resident required total assistance from staff for transfer and locomotion. The resident was unable to stand and her sitting balance was unsteady. Resident 1's primary mode of locomotion was a wheelchair. Section J4 (accidents) indicated the resident fell in the past 31 to 180 days.</p> <p>The RAP Summary dated March 3, 2010, indicated</p>		<p>-Fire doors on east end of unit closed</p> <p>• <i>How we will identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken:</i></p> <p>-All residents have the potential to be affected by the deficient practice.</p> <p>-All residents assessed for wandering behavior and wheelchair safety</p> <p>• <i>This deficient practice will not recur because of the following measures and/or systemic changes:</i></p> <p>-Implementation of alarms on West stairwell</p> <p>-Staff in-services about hand-off communication with emphasis on verbal hand-off</p> <p>• <i>The corrective action(s) will be monitored to assure that solutions are sustained. The plan for ensuring correction is integrated into the quality assurance system by:</i></p> <p>-Nursing supervisors monitor hand-off communications and immediately address any concerns. Results of monitoring reported at staff meetings.</p>	10/22/10
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	<p>Continued From page 2</p> <p>the resident had cognitive loss due to Alzheimer's dementia and the plan was to provide a safe environment daily. (Resident assessment protocols (RAPs) are a component of MDS. RAPs are a record of 18 medical concerns which, when triggered on an MDS, indicate that a nursing home patient requires additional medical attention.)</p> <p>A review of the Social Services notes, dated November 5, 2008 and January 23, 2009, indicated Resident 1 self-propels in a wheelchair around the unit and has episodes of leaving the unit with some success (AWOL type behavior, leaving the unit without staff knowing). A review of the Long-Term Care Notes, dated June 11, 2009, indicated Resident 1 demonstrating some delusions of elopement-type behavior. A review of the Social Services Annual notes dated March 3, 2010 at 2:35 p.m., indicated "Resident 1 presents in her wheelchair as confused and disoriented, alert to her name only."</p> <p>A review of the IDT notes dated March 10, 2010 at 11:07 a.m., indicated "Resident 1 was seen by a geriatric psychiatrist on [REDACTED] 2010 for increased sundowning (aberrant behaviors that occur in the late afternoon or evening; i.e., agitation, depression, rapid mood changes, restlessness and wandering); started on routine Seroquel for agitation.</p> <p>A review of the Social Services 'room change' notes dated June 10, 2010 at 2:56 p.m., indicated Resident 1's niece was reminded that the resident was scheduled to move on [REDACTED], 2010 from a</p>		<p>-Routine security rounds, conducted approximately every two hours, continue to include checking stairwell alarms and fire doors. Any concerns are reported and corrected immediately. Reports are provided periodically to the Environment of Care Committee.</p> <p>• <i>Dates corrective actions will be completed.</i></p> <p>Immediate correction: 10/22/10 Permanent corrections: 11/17/10</p>	11/17/10
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	<p>Continued From page 3</p> <p>one story building to the second floor of a two story building, where she had previously fallen down a flight of stairs in [REDACTED] 2007.</p> <p>A review of the "Falls/Increased risk for injury" care plan updated on September 14, 2010 identified "Resident 1 to be at an increased risk for injury due to osteoporosis, Alzheimer's disease, extensive assist with transfers, use of antidepressant/antianxiety/antihypertensive meds, unsteady sitting balance, poor safety judgment, and falls asleep in wheelchair. The goal was to have no falls/injuries daily. The staff's plan of approaches included: bed in low position; call bell within reach at all times while in room; anticipate and meet needs; bed alarm when in bed; monitor frequently; monitor for leaning while in wheelchair and position at table when leaning or when she tends to fall asleep; resident likes to sit near or at nurses station when she is up in her wheelchair."</p> <p>A review of the facility's Occurrence Screening Falls Investigation Report, dated October 17, 2010 at 2:45 p.m., indicated the resident had a history of falls in 2007, 2008, and 2009; a total of eight falls in three years. The investigation report indicated the resident wandered down the hallway and sustained a fall on [REDACTED] 2010, (time not found); a wheelchair alarm was heard in the south corridor, staff went immediately and found the resident near the elevator on the floor next to her wheelchair. The investigation report indicated the resident did not sustain any injuries and was assisted back to her wheelchair.</p>			
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	<p>Continued From page 4</p> <p>A short term care plan titled "Actual Fall", dated October 14, 2010 indicated "One of the staff's care plan approaches was to update the long term falls care plan with recommendations from the fall committee." A review of the long term falls care plan was made with Employee C, Director of Quality Resources. Employee C indicated the fall committee met on October 21, 2010, to review and evaluate Resident 1's medications and change of behaviors regarding the fall on [REDACTED] 2010; Employee C stated there were no recommendations from the fall committee documented, as the resident was still in the hospital. There was no updated documentation to the long term care plan after the [REDACTED] 2010 fall addressing the "resident's safety regarding wandering behavior" in trying to wheel self out of the building that morning.</p> <p>A review of the Certified Nursing Attendant (CNA) Long Term Care (LTC) Daily Nursing Record, dated [REDACTED], 2010 at 3:55 p.m., indicated at 2:45 p.m. CNA 1 found Resident 1 on the landing of the stairwell that goes up to the second floor, west side of the building. Resident 1's wheelchair was lodged at the third step down from the second floor. Resident 1 was found face up, yelling and complaining of neck pain. CNA 1 told Resident 1 to stay still; CNA 1 ran up the stairs, opened the door to the second floor and yelled for help. LVN 5 (2W) and LVN 1 (2E) responded immediately to the location of the incident. CNA 1 paged the Rapid Response Team (RRT) and the Nursing Supervisor. Within a few minutes, the RRT was there; the physician assessed the resident, decided not to</p>			

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	<p>Continued From page 5</p> <p>move her and had "911" called.</p> <p>A review of the facility's Occurrence Screening Falls Investigation report, dated October 17, 2010 at 2:45 p.m., indicated Respiratory Therapist (RT 2) who cared for Resident 1 during the day was interviewed. RT 2 stated he had given the resident a respiratory treatment earlier that morning. He stated that after the treatment, the resident appeared more anxious than normal, but he did not report this to the charge nurse.</p> <p>A review of the facility's Investigative Report, initiated on October 18, 2010 and completed on November 18, 2010, indicated on October 17, 2010 at 2:10 p.m., Employee J, Activities Staff, received report from RT 1 that Resident 1 was observed in the hallway, outside of the activities room, wandering toward 'J wing' and found near the exit door. Employee J decided to return Resident 1 to the unit, due to her wandering toward the exit door, at approximately 2:15 p.m. He brought the resident to the table next to the north end of the nurses' station on 2E where he observed LVN 1 talking to a resident and her son; he did not speak to LVN 1 to inform her of Resident 1's wandering towards the exit door on the first floor, but knew they were close enough to be aware that Resident 1 had returned to the unit.</p> <p>A review of the facility's Investigative Report, initiated on October 18, 2010 and completed on November 18, 2010, indicated there was no documentation of assessment of Resident 1's previous wandering behavior prior to her move from</p>			

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	<p>Continued From page 6</p> <p>the Pavilion (one story building) to 2E (a two story building) in ██████ 2010; there was no documentation of assessment of Resident 1's wandering behavior after the move to 2E; and, there was no documentation of concerns or of informing the physician or nurse practitioner regarding Resident 1's wandering behavior in days prior to the fall on ██████ 2010.</p> <p>A review of the acute care hospital Physician Documentation record indicated Resident 1 was brought to the hospital on ██████ 2010 at 3:53 p.m., after a fall from one flight of stairs with complaint of pain in head, neck, and back. A review of the computed tomography (CT, a machine that uses X-rays to make detailed pictures of structures inside the body) scan reports, dated ██████ 2010 at 4:46 p.m., indicated a burst fracture (a vertebra, spine bone, is crushed in all directions) of the C1 (the first spine bone closest to the skull) vertebral body and a fracture slightly displaced posteriorly (back) on the body of C2 (the second spine bone, C1 and C2 forms the joint connecting the skull and spine); a greater than 75% vertebral body compression fracture of L1 vertebral body with angulation at that level (more than 75% of the front portion of the first lower back bone was collapsed and twisted); and, a non displaced fracture of the left tenth rib.</p> <p>A review of the Consultation report, written by Physician 3, Neurosurgical consult, dated October 18, 2010 at 10 a.m., indicated after consult with Physician 8, a collective decision was made to place the resident in a Minerva brace (a cervical</p>			

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	<p>Continued From page 7</p> <p>and upper thoracic orthosis to provide good orthotic control of the neck) and a C-collar (cervical collar is used to stabilize the head and neck).</p> <p>A review of the Physician's Orders, written by Physician 1, dated October 21, 2010 at 6:10 a.m., indicated "A Palliative Care Consult ordered and called by Physician 1."</p> <p>A review of the Progress Note, written by Physician 5, Palliative Care Specialist, dated October 21, 2010 at 3:09 p.m., indicated the resident was deemed to not be a surgical candidate by Physician 1 and Physician 3, Neurosurgery/Trauma Surgery, due to the extent of her injuries, other health co-morbidities, and her age. According to the hospital record, there was no documentation of falls while Resident 1 was in the hospital from [REDACTED] to [REDACTED], 2010. In addition, there was no evidence of any events that occurred which may have exacerbated the resident's diagnosis of a burst fracture of the neck when she was first admitted to the hospital on [REDACTED] 2010.</p> <p>A review of the skilled nursing facility's Registration Record indicated Resident 1 was readmitted on [REDACTED] 2010 at 3:26 p.m., with diagnoses that included fracture C1 vertebrae and Alzheimer's dementia with behavior disorder. A Minerva brace was in place.</p> <p>A review of a Progress Note/Clinic Note, written by Physician B, dated October 23, 2010, indicated "The resident has not been able to eat much since her return. Dehydration, therefore, appears to be</p>			
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an imminent danger." Physician B spoke with resident's niece to discuss possible options of continued palliative care and use of a feeding tube to meet the resident's nutritional needs. After discussion, it was decided to insert a feeding tube to provide the resident an opportunity at being given an appropriate degree of nutrition.

A review of the Physician Progress Notes, written by Physician A, House MD, dated [REDACTED] 2010 at 5:38 a.m., indicated he was called by nursing with a report that Resident 1 had expired. When Physician A arrived, Resident 1 had agonal respirations (an abnormal pattern of breathing characterized by gasping, labored breathing, accompanied by strange vocalizations and myoclonus), hands warm, lips cyanotic (bluish) and no response to pain; dying but not pulseless nor apneic. Resident 1 was a "do not resuscitate/do not intubate" (DNR/DNI); no code was called. At 5:44 a.m., Resident 1 now apneic (not breathing), pulseless and without heart tones, was pronounced dead by Physician A.

A review of the Certificate of Death indicated the immediate cause of death was "Sequelae of Fall."

On December 1, 2010 at 12:15 p.m., during an interview, Employee B stated after a review of Resident 1's medical record: "There was no care plan that addressed the wheelchair alarm use; there was no documentation of assessment or care plan regarding Resident 1's wandering behavior prior to her move from the Pavilion unit to 2E on [REDACTED], 2010; there was no documentation

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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: 055034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2011
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NAME OF PROVIDER OR SUPPLIER MOTION PICTURE & TELEVISION HOSPITAL D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 23388 MULHOLLAND DR., WOODLAND HILLS, CA 91364 LOS ANGELES COUNTY
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(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
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	<p>Continued From page 9</p> <p>regarding Resident 1's wandering behavior in days prior to the fall on [REDACTED] 2010 informing the physician or nurse practitioner; there was no documentation of any report from RT 2, to nursing staff regarding Resident 1's breathing treatment the morning of the accident and how the RT 2 felt the resident was more anxious than normal after the breathing treatment; and, there was no documentation of any report from Employee J, Activity Staff, regarding the reason he brought Resident 1 back to the unit that afternoon."</p> <p>The facility failed to provide a safe environment and adequate supervision to Resident 1, who had dementia with history of falls, from exiting the door to a flight of the stairs. Resident 1 had previously fallen down the same flight of stairs in [REDACTED] 2007 without injuries. On [REDACTED] 2010, Resident 1 wheeled herself out the second floor through the West exit door to the stairwell. Resident 1 fell out of the wheelchair between the first and second floors and sustained a burst fracture of her neck and a severe lumbar fracture. Surgery was not medically recommended, and subsequently, the resident expired seven days later on [REDACTED] 2010.</p> <p>The above violation presented either imminent danger that death or serious harm would result or substantial probability that death or serious physical harm would result and was a direct proximate cause of the death of the patient.</p>			
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Event ID:06KL11

12/29/2011

8:50:59AM

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

TITLE

(X6) DATE

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