

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2008
NAME OF PROVIDER OR SUPPLIER NEW HOPE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2586 BUTHMANN AVENUE, TRACY, CA 95376 SAN JOAQUIN 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>Representing the Department of Public Health: [REDACTED], HFEN</p> <p>CLASS AA CITATION -- PATIENT CARE 03-1662-0006469-F Complaint(s): CA00164153</p> <p>F157 483.10 - Notification Of Changes (b)(11) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in 483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in 483.15(e)(2); or a change in resident rights under Federal or</p>			

Event ID:DWKV11

8/20/2009

1:14:21PM

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: 555245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2008
NAME OF PROVIDER OR SUPPLIER NEW HOPE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2586 BUTHMANN AVENUE, TRACY, CA 95376 SAN JOAQUIN 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>State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>F309 483.25 - Quality Of Care Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>F329 483.25 - Unnecessary Drugs (l) Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use</p>				

Event ID:DWKV11

8/20/2009

1:14:21PM

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: 555245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2008
NAME OF PROVIDER OR SUPPLIER NEW HOPE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2586 BUTHMANN AVENUE, TRACY, CA 95376 SAN JOAQUIN 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>antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>An unannounced visit was made to the facility on 09/26/08 to initiate and investigation of complaint #CA00164153.</p> <p>The Department determined the facility failed to:</p> <ol style="list-style-type: none"> 1) Ensure the resident receiving anticoagulation therapy was appropriately monitored. 2) Ensure the resident was fully assessed when there was a change in neurological status and a consultation with the physician occurred when there was a need to alter treatment. 3) Ensure an immediate transfer to the acute care hospital for intervention in an emergency situation. <p>These failures resulted in Resident A having a PT of 29.0 (Reference 11.5-14.5 sec) and an INR that was 2.7 (Reference 0.9-1.1) at the General Acute Care Hospital and sustaining a "large intracerebral (brain) hemorrhage involving the right hemisphere, 8 x 6 x 7 cm, with a shift of the midline structures and extension of the hemorrhage into the brain stem" that was "certainly exacerbated by her anticoagulation." Resident A expired two days later.</p>			

Event ID:DWKV11

8/20/2009

1:14:21PM

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: 555245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2008
NAME OF PROVIDER OR SUPPLIER NEW HOPE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2586 BUTHMANN AVENUE, TRACY, CA 95376 SAN JOAQUIN 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>Prothrombin Time (PT) is used to evaluate the ability of blood to clot. International Normalized Ratio (INR) is used to monitor the effectiveness of blood thinning drugs such as Coumadin (warfarin). Coumadin is a high risk medication that interacts with many other medications such as acetaminophen (Tylenol), aspirin, ciprofloxin (an antibiotic) and Lovenox (which Resident A was also receiving.) These additional medications with possible interactions with Coumadin could significantly increase the resident's potential for bleeding.</p> <p>Resident A's clinical record documented she was a 78 year old female originally admitted to the facility on 08/22/08. Her diagnoses included a recent hip fracture, mitral/aortic heart valve insufficiencies, general osteoarthritis, osteoporosis and hypertension.</p> <p>Resident A's admission Minimum Data Set (MDS, a standardized assessment tool) dated 09/04/08, documented Resident A as having no short and long-term memory problems, as having independent cognitive skills for daily decision making, as having clear speech, able to make herself understood and able to understand others. The MDS also documented Resident A as needing limited assistance with bed mobility, locomotion on and off the unit, dressing and personal hygiene and as needing extensive assistance with transfers, walking in room, walking in corridor, and toilet use.</p>				

Event ID:DWKV11

8/20/2009

1:14:21PM

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: 555245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2008
NAME OF PROVIDER OR SUPPLIER NEW HOPE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2586 BUTHMANN AVENUE, TRACY, CA 95376 SAN JOAQUIN 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>According to the August 2008 "Physician Order Sheet", Resident A was receiving Coumadin (an anticoagulant (blood thinner) that reduces the formation of blood clots) 2 mg (milligrams) by mouth at "hour of sleep" and was on aspirin 81 mg by mouth every day, which also has anti-clotting potential. The anticoagulation therapy was to prevent clot formation from her mitral valve disease and/or deep vein thrombosis (DVT - clot formation in the deep veins of the lower extremities). Resident A's August 2008 "Physician Order Sheet" documented Resident A was to have a PT/INR drawn on Monday, Wednesday and Friday for one week. Anticoagulant drug therapy must be carefully monitored to maintain a balance between preventing clots and causing excessive bleeding.</p> <p>The Federal Drug Administration has issued a Black Box Warning for Coumadin noting additional concerns identified for elderly patients and their increased risk for bleeding. The warning is published in the American Hospital Formulary Service published by the American Society of Health System Pharmacists. The warning states (in part): "Boxed Warning: Bleeding: May cause major or fatal bleeding. Risk factors for bleeding include high intensity anticoagulation (INR >4), over age 65 years, variable INRs, history of GI (Gastro-intestinal) bleeding, high blood pressure, cerebrovascular disease, serious heart disease, anemia, etc...Special</p>				

Event ID:DWKV11

8/20/2009

1:14:21PM

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: 555245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2008
NAME OF PROVIDER OR SUPPLIER NEW HOPE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2586 BUTHMANN AVENUE, TRACY, CA 95376 SAN JOAQUIN 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>populations: Elderly: The elderly may be more sensitive to anticoagulant therapy. Geriatric Considerations - Before committing an elderly patient to long-term anticoagulation therapy, the risk for bleeding complications secondary to falls, drug interactions, living situation, and cognitive status should be considered. A risk of bleeding complications has been associated with increased age.</p> <p>Adverse Reactions: Bleeding is the major adverse effect of Coumadin (warfarin). Hemorrhage may occur at virtually any site. Risk is dependent on multiple variables, including the intensity of anticoagulation and patient susceptibility...Central nervous system: Coma, dizziness, fatigue, fever, headache, lethargy, malaise, pain, stroke."</p> <p>Resident A's PT/INR was drawn on 08/25/08, as ordered. Her PT was 18.8 (Reference Units Range 12.8-14.8 sec (seconds) for patients not on anticoagulation therapy) and her INR was 1.48 (Reference Units Range 0.90-1.10 for patients not on anticoagulation therapy). On the bottom of the PT/INR lab results, dated 08/25/08, was an order for Resident A's Coumadin to be changed to 2 mg on Sunday, Monday, Wednesday, Thursday and Saturday. And 3 mg of Coumadin on Tuesday and Friday, representing an increase in anticoagulation therapy). There was also an order for Resident A's INR to be rechecked on 09/02/08.</p> <p>Review of Physician's Orders revealed an</p>				

Event ID:DWKV11

8/20/2009

1:14:21PM

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: 555245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2008
NAME OF PROVIDER OR SUPPLIER NEW HOPE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2586 BUTHMANN AVENUE, TRACY, CA 95376 SAN JOAQUIN 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 6</p> <p>order, dated 08/26/08, for the following: all PT/INR results to be called to physician, Lovenox (another anticoagulation medication) Injections 40 mg daily (start first dose tonight), increase Coumadin to 3mg every day and PT/INR on Thursday, another increase in Resident A's anticoagulation therapy.</p> <p>An order, dated 08/30/08, indicated that the Lovenox was to be discontinued when the PT/INR was above 2.0</p> <p>Resident A's PT, on 09/02/08, was 17.4 and INR was 1.34. A Physician's Order was received on 09/03/08 at 10:15 p.m. for the discontinuation of Coumadin 2 mg by mouth Tuesday, Thursday, Saturday and Sunday. Also discontinuation of Coumadin 3 mg on Monday, Wednesday and Friday, to continue Coumadin at 4 mg by mouth every day (an increase in anticoagulation therapy) and to recheck PT/INR on 09/06/08.</p> <p>Review of Resident A's PT/INR lab results on 09/06/08 documented her PT was 15.7 and her INR was 1.6. The bottom of the lab results, dated 09/06/08, documented a telephone order, on 09/06/08 at 6:00 p.m., for the same dose of Coumadin to be continued. There were no further orders for laboratory monitoring of the effects of anticoagulation therapy. The Lovenox was also continued with no new parameters to discontinue and no monitoring process in place.</p>				

Event ID:DWKV11

8/20/2009

1:14:21PM

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: 555245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2008
NAME OF PROVIDER OR SUPPLIER NEW HOPE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2586 BUTHMANN AVENUE, TRACY, CA 95376 SAN JOAQUIN 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 7</p> <p>There was no documented evidence that the facility consulted with the physician to ensure ongoing monitoring occurred. Resident A continued to receive the Lovenox through 09/13/08, continued to receive the Coumadin through 09/13/08 and continued to receive the aspirin through 09/14/08.</p> <p>Resident A's family documented that at around 8:00 a.m. on 09/14/08, Resident A's son arrived at the facility. He stated Resident A complained of "having a sinus headache and was slow in speaking. Resident A had already told staff she was not feeling well. At around 8:50 a.m. Resident A falls asleep. Resident A's son went home to tell his father (Resident A's husband) that Resident A was sleeping. Resident A's husband was concerned because Resident A never would sleep so soon after waking up in the morning."</p> <p>According to the family's statement, at around 9:30 a.m. on 09/14/08 Resident A's husband arrived at the facility and noticed "that things do not seem right with her." At about that time Resident A's daughter called and Resident A's husband told her Resident A couldn't talk to her because she had a bad headache."</p> <p>At around 9:45 a.m. when staff "finally came back in" Resident A's husband told staff that Resident A needed to go to the hospital due to she was "slurring her words" and was "not responsive." Resident A's husband was concerned that the facility was not "moving with</p>			

Event ID:DWKV11

8/20/2009

1:14:21PM

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: 555245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2008
NAME OF PROVIDER OR SUPPLIER NEW HOPE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2586 BUTHMANN AVENUE, TRACY, CA 95376 SAN JOAQUIN 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 8</p> <p>urgency." The statement documented that Resident A was given some medication and the husband was told that the "head nurse will be called." Resident A's husband was "very concerned" because he "felt like the staff was not taking her condition as seriously as he knew they needed to."</p> <p>At around 11:30 a.m. Resident A's daughter arrived at the facility. Resident A was described as not being able to "understand any conversation" and was "vomiting." Resident A's speech was again described, by family, as "slurred" and that Resident A was "in extreme pain." Resident A had a cloth over her eyes and was repeating, "My head, my head." At around 12:00 p.m. the ambulance arrived and Resident A was taken to the general acute care hospital (GACH) "where she never regained consciousness."</p> <p>Review of Resident A's "Vital Sign & Weight Flow Sheet" documented Resident A's systolic blood pressure (top number), from 09/10/08-09/13/08, ranged from 108-126 and her diastolic blood pressure (bottom number) ranged from 60-68.</p> <p>A Nurse's Note, dated 09/14/08 at 9:30 a.m. documented Resident A complained of a "headache and pain on the back of neck." Resident A was described as "sleepy and weak" and her vital signs were the following: Temperature: 100.9, Pulse: 70, Respiration: 20, B/P: 169/98. The Nurse's Note documented that Resident A's physician was</p>				

Event ID:DWKV11

8/20/2009

1:14:21PM

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: 555245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2008
NAME OF PROVIDER OR SUPPLIER NEW HOPE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2586 BUTHMANN AVENUE, TRACY, CA 95376 SAN JOAQUIN 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 9</p> <p>contacted but was not in. The on-call physician called the facility with an order for a CBC (complete blood count), UA (urinary analysis) and Rocephin (antibiotic) 1 gm IM (intramuscular) times 1 dose at 9:45 a.m. and called again at 11:00 a.m. to change the antibiotic orders. An order to transfer Resident A to the GACH was not received until 12:45 p.m. According to a Nurse's Note, dated 09/14/08 at 12:45 p.m., Resident A's family was at the facility and were "really concerned because resident is still weak, threw up 1 x (time). Family wants resident to be sent to ER." The Nurse's Note documented an order was received from the on-call physician to transfer Resident A to the ER. According to the Nurse's Note, paramedics arrived at the facility at 12:55 p.m. and Resident A was transferred to the ER.</p> <p>Review of Resident A's General Acute Care Hospital (GACH) 1 medical record revealed Resident A's PT, drawn on 09/14/08 at 1:55 p.m., was 29.0 and her INR was 2.7.</p> <p>Review of Resident A's "Consultation" report from GACH 1, dated 09/14/08, documented "the patient (Resident A) was brought in today with a chief complaint of altered level of consciousness. The patient was seen by family earlier today, around 9:00, and the patient seemed to have some difficulty with speaking and since then the patient has had progressive weakness, so the patient was brought in to the emergency room." "...the</p>				

Event ID:DWKV11

8/20/2009

1:14:21PM

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: 555245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2008
NAME OF PROVIDER OR SUPPLIER NEW HOPE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2586 BUTHMANN AVENUE, TRACY, CA 95376 SAN JOAQUIN 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 10</p> <p>patient was able to follow commands. The patient was comprehending conversation but was unable to speak. The patient had a left dense hemiplegia (paralysis). The patient's CT scan of the head was done already, which showed a 7 mm midline shift from right to left with large basal ganglia hemorrhage. The process of Coumadin reversal was started with Vitamin K, as well as, fresh-frozen plasma." "The patient's vital signs were hypertensive with a systolic blood pressure of 160-170. The patient while in the emergency room continued to have progression with decreased level of consciousness. The patient's right pupil became dilated by about 2-3 mm more than the left."</p> <p>Under the section "Impression" of the "Consultation" report documented "Acute intracranial hemorrhage involving right basal ganglion with midline shift and brain stem herniation."</p> <p>Review of a form titled "Physician Certification," dated 09/14/08, documented Resident A was transferred to a facility providing a higher level of care, GACH 2, to be seen by a neurosurgeon.</p> <p>Resident A's medical records from GACH 2 contained a "Consultation Report," dated 09/14/08, that documented that Resident A had a "large intracerebral hemorrhage involving the right hemisphere, 8 x 6 x 7 cm, with a shift of the midline structures and</p>				

Event ID:DWKV11

8/20/2009

1:14:21PM

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: 555245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2008
NAME OF PROVIDER OR SUPPLIER NEW HOPE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2586 BUTHMANN AVENUE, TRACY, CA 95376 SAN JOAQUIN 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 11</p> <p>extension of the hemorrhage into the brain stem. This unfortunate woman sustained a large intracerebral hemorrhage perhaps related to underlying hypertension, but certainly exacerbated by her anticoagulation. At this point there is no evidence of upper brain stem function. Her prognosis is extremely poor."</p> <p>During a telephone interview with the Director of Nursing (DON), on 09/29/08 at 1:10 p.m., she confirmed Resident A's PT/INR was not rechecked after 09/06/08. When asked if the facility had a policy regarding residents on Coumadin and/or monitoring of residents on Coumadin, the DON stated she did not and that the facility used a generic reference text for nursing which indicated the need to draw PT/INR as ordered by the physician. She also confirmed someone should have followed up with the physician to clarify when Resident A's PT/INR should have been rechecked.</p> <p>The facility failed to assess the onset of symptoms indicating a possible intracranial bleeding episode, failed to contact the physician immediately when there was a need to alter treatment and failed to expedite immediate transfer to the GACH resulting in delayed medical assessment, interventions and treatment.</p> <p>In a written and signed declaration, family members stated that at 8:00 a.m., Resident A had complained to facility staff about her</p>			

Event ID:DWKV11

8/20/2009

1:14:21PM

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: 555245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2008
NAME OF PROVIDER OR SUPPLIER NEW HOPE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2586 BUTHMANN AVENUE, TRACY, CA 95376 SAN JOAQUIN 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 12</p> <p>headache and then fell asleep. At 9:00 a.m., Resident A was called by her husband who sensed something was wrong because she was "not thinking straight, was foggy and her head hurt." He immediately went to the facility. He found her to be "lethargic, sleepy and unable to carry on a conversation." Facility staff had not yet assessed the resident. The nurse informed the husband that she had "paperwork to do" and she would "send someone down and call the doctor when I am finished." Despite family request(s), the Resident was not assessed until hours later when family insisted that 911 be called and his wife taken to the GACH. Staff failed to assess the resident's change in neurological and general status and need to alter treatment significantly.</p> <p>Resident A expired on 09/16/08 and according to her "Certificate of Death" Resident A's immediate cause of death was "Intracranial hemorrhage with herniation" and "hypertension." The "Certificate of Death" also documented under the section "Other significant conditions contributing to death was "Coagulopathy (inappropriate bleeding or clotting) secondary to medication."</p> <p>The Department determined the facility failed to:</p> <p>1) Ensure the resident on anticoagulation therapy and receiving three medications that alter blood clotting factors was appropriately monitored.</p>				

Event ID:DWKV11

8/20/2009

1:14:21PM

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: 555245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2008
NAME OF PROVIDER OR SUPPLIER NEW HOPE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2586 BUTHMANN AVENUE, TRACY, CA 95376 SAN JOAQUIN 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 13</p> <p>2) Ensure the resident was fully assessed when there was a change in neurological status and that the facility immediately consulted with the physician when there was a need to alter treatment.</p> <p>3) Ensure an immediate transfer to the acute care hospital for intervention in an emergency situation.</p> <p>These violations presented 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 death of the patient or resident.</p>				

Event ID:DWKV11

8/20/2009

1:14:21PM

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.