

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2010
NAME OF PROVIDER OR SUPPLIER SAN FRANCISCO NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5767 MISSION STREET, SAN FRANCISCO, CA 94112 SAN FRANCISCO COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit:</p> <p>CLASS AA CITATION -- IMMEDIATE JEOPARDY 22-1163-0007568-F Complaint(s): CA00222459</p> <p>Representing the Department of Public Health: Surveyor ID # 11027, Health Facilities Evaluator</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 223 483.13(b)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This Regulation was not met as evidenced by:</p> <p>The facility failed to provide Resident 1 the right to be free from deadly assault when: 1. the Administrator, Director of Nursing (DON), Director of Staff Development (DSD), LVN 1, and LVN 2 neglected to monitor, supervise and</p>			

Event ID:G7M511

4/12/2011

10:24:16AM

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

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	<p>Continued From page 1</p> <p>evaluate CNA 1's hiring, training, and orientation process. The administrative staffs were aware that CNA 1 had no related nursing experience specifically on the care of the elderly and 7 residents were assigned to his care on the first day of work.</p> <p>2. the Director of Staff Development (DSD) failed to complete/document a Post Training Performance Evaluation to determine CNA 1's skills and competency in performing patient care.</p> <p>3. the facility did not develop a policy and procedure on Post Training Performance Evaluation.</p> <p>4. the licensed staff failed to conduct an orientation and direction to make sure that CNA 1 had knowledge of the individual needs of the 7 residents assigned to him.</p> <p>5. the Director of Nursing (DON) failed to acknowledge and act upon CNA 3's request to check on CNA 1 since it was a bathing day for the residents and that CNA 3 was not sure if CNA 1 was capable of doing the task for the 7 residents assigned to his care.</p> <p>The facility's systemic failure in monitoring, supervising, and evaluating CNA 1's performance on his first day of work caused an immediate jeopardy on the 7 residents' health and safety. Resident 1 died due to suffocation when CNA 1 smothered her face with a pillow.</p> <p>Resident 1 died due to suffocation when CNA 1 smothered her face with a pillow.</p>				

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	<p>Continued From page 2</p> <p>Resident 1 was admitted to the facility on 12/4/2009 with diagnoses including dementia with delusions, cerebrovascular accident (stroke), and osteoporosis (fragile bones that easily fracture). The minimum data set (MDS-assessment tool) dated 3/17/10 indicated that Resident 1 had short-term and long-term memory problems, moderately impaired decision making, totally dependent on facility staff in all areas of activities of daily living, and had limited range of motion on both upper and lower extremities.</p> <p>On 3/22/10 at 10:05 AM, CNA 2 went to Room 21-1 and saw CNA 1 standing on the right side of the resident's bed. CNA 2 said CNA 1 had a pillow over the resident's face. When CNA 2 raised the pillow she saw CNA 1's fingers "pinching the resident's nose." CNA 2 said she screamed, "What are you doing?" CNA 1 ran out of the building. CNA 2 said the resident's face turned blue and she yelled for help.</p> <p>During an interview on 3/23/10 at 9:00 AM, the Administrator, Director of Nursing (DON), Director of Staff Development (DSD) said that on 3/22/10 at approximately 10:00 AM, facility staff members were in the hallway and were pointing to Room 21 but they did not say anything. The Administrative staff stated that many of the staff members were in some form of "shock", unable to carry out their duties, there was a "panicky" atmosphere throughout the facility, and many of the staff members were not able to speak coherently. The</p>				

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	<p>Continued From page 3</p> <p>Administrator and the DON said they went to Room 21 and found Resident 1 to be unresponsive and pale. The DON stated that at that time facility staff members were unable to assist her in checking the Resident's medical record for her cardiopulmonary resuscitation (CPR) status or in providing the actual CPR. The DON said she had to continue doing CPR on Resident 1 until the paramedics arrived. San Francisco Police Department was notified.</p> <p>The information received from San Francisco Police Officer #713, Report #100269-433 indicated, "On 3/22/10, at about 1015 hours, a nurse at the facility went to Room 21, on the main floor of the facility, and found one of the male nursing assistants in the room standing over the subject with a pillow over her face. At that time, the male nurse fled the scene, running down the hallway of the nursing home, through the front door and out to the street." CNA 1 was apprehended by an off duty officer and some individuals who were alerted with the commotion.</p> <p>During an interview on 3/23/10 at 2:05 PM, Housekeeper 1 (HS 1) stated that she entered Resident 1's room just before 10:00 AM and saw that the privacy curtain was pulled all the way around the Resident's bed. HS 1 said she moved the curtain a little and saw CNA 1 standing next to the right side of Resident 1. She said the pillow was covering the Resident's face. She asked CNA 1 if he needed any help and he told her to get out of the room. HS 1</p>				

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	<p>Continued From page 4</p> <p>then left the room to go to the bathroom. When the Surveyors asked her if it looked like CNA 1 was cleaning the Resident or providing care for her HS replied, "No, no."</p> <p>During an interview on 3/23/10 at 2:30 PM, LVN 1 said that during the morning of 3/22/10 she was going to take his break and then return to provide care for Resident 2 LVN 1 indicated that she asked CNA 1 if he needed some help and each time he replied that he was okay.</p> <p>In an interview with the Administrative staff on 3/24/10 at 10:20 AM, the Administrator said he had favorable encounters with CNA 1 from the time he was hired on 3/9/10. He added that CNA 1 was friendly and showed an interest in his work. The Administrator stated he was quite shocked at CNA 1's involvement in the 3/22/10 incident.</p> <p>The DON was asked why she had hired CNA 1 and whether he had displayed any type of unusual behavior prior to the incident. The DON said CNA 1 was very motivated to be hired as a CNA and that he was persistent in securing employment. The DON added that she had not noticed any unusual behavior since the day he was hired on 3/9/10 and that CNA 1 was very cordial, helpful and cooperative. The DON was asked why CNA 1 was assigned to independently care for seven residents on his first day of work especially in view of his lack of experience. The DON stated she thought he was ready for this assignment</p>				

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	<p>Continued From page 5</p> <p>but she could not substantiate this opinion through any feedback from the DSD, the orientation trainer. She added that the DSD was the primary mentor during the orientation phase and added that she had not reviewed each of the CNA's performance during the two-week training with the DSD.</p> <p>In a concurrent interview, the DSD explained her role during the overall employment process and in particular the initial employee orientation. This included screening, application review, coordination of background checks and references, final hiring, classroom orientation and hands-on performance involving new employees shadowing other more experienced CNAs while providing care.</p> <p>A copy of the "Day Shift Assignment Sheet" for 3/22/10 was reviewed. The total census was 50 residents. CNA 1 was assigned to the day shift and responsible for providing care to seven (7) residents. The facility was aware that he had no experience working with elderly and frail residents in a nursing home or similar environment.</p> <p>The DON acknowledged that this was CNA 1's first day on the job and that he would be working without any direct supervision while providing care to seven residents. There was no documented evidence or any assessment or evaluation of CNA 1's performance during the two week orientation and training which may have indicated that CNA 1 was qualified</p>				

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	<p>Continued From page 6</p> <p>and prepared to independently care for residents.</p> <p>On March 24, 2010 at 2:10 PM, LVN 2 was interviewed regarding his role and function during the morning of 3/22/10. LVN 2 was listed as the Supervisor/Charge Nurse of CNA 1 during the day shift on 3/22/10. LVN 2 said that CNA 1 was new and was assigned to Resident 1, in addition to six other residents. When asked if he provided CNA 1 with any of the residents' background or diagnoses information before he began his assignment, LVN 2 responded, "No, I did not. I am sorry." LVN 2 stated that he did not know what CNA 1 was doing between 7:00 AM and 10:00 AM. He added that when he was giving medications at approximately 9:46 AM, he saw CNA 1 walking in the hallway near the stand-up meeting room. When asked if he knew what was happening in the facility at approximately 10:00 AM, LVN 2 said he saw staff members running in the hallway towards Room 21. He stated that he did not know what was happening. Someone shouted, "Call 911", and he did.</p> <p>An interview was conducted with CNA 3 on 7/13/10 at 11:15 AM. CNA 3 said that on the morning of 3/22/10, prior to Resident 1's death, she noticed CNA 1 to be very confused and disoriented. CNA 3 suggested to the DON, "at least 3 times," that she should check on CNA 1 since it was bathing day and CNA 3 was not sure if CNA 1 was capable of doing this. CNA 3 said that every time she told the DON, her</p>				

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	<p>Continued From page 7</p> <p>request was denied. She then asked other employees to check on CNA 1. One employee reported back that he also thought CNA 1 was 'on drugs'. Each time they complained, the DON told them it was okay. CNA 3 added that the DON never checked on CNA 1. CNA 3 said that within 30 minutes of conversing with the DON, Resident 1 was dead. CNA 3 stated that at this point or shortly after, the DON apologized to the complaining attendant (CNA 3) at a later time when the incident had passed. According to CNA 3 she told the Administrator what had happened on 3/22/10. He reassured her that he would speak to the DON but nothing ever came of it. CNA 3 added that she is still very much traumatized by all the events.</p> <p>A review of CNA 1's employment application and his attached resume provided no supportive documentation of health care experience. During an interview on 4/8/10 at 10:10 AM, the DSD said that CNA 1 was very eager to be hired. When asked why CNA 1 was hired in spite of having no patient care or elder care nursing experience, the DSD indicated that he was eager to learn and well motivated. She was unable to substantiate CNA 1's attestations of his relevant experience. The DSD said that she was responsible for the overall hiring and training for all new employees. She stated that all new CNAs were required to complete a two week orientation training prior to being independently assigned to provide care to their assigned residents.</p>				

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	<p>Continued From page 8</p> <p>She added that on Day 1 the newly hired CNAs would review the facility's policies, procedures and corporate core values. On Day 2 - Day 10: the CNAs were assigned to observe some of the more experienced CNAs while they performed their patient care duties.</p> <p>During this two week training, the DSD indicated that CNA 1 did not ask many questions, if any, but was polite and friendly during this orientation period. When asked if the new CNAs received any Post Training Written Performance Evaluation, the DSD responded, "No." The facility did not have a policy and procedure on Post Training Written Evaluation. When the DSD was asked if she reviewed the individual CNAs' strengths and weaknesses with the DON and respective Charge Nurses, the DSD answered, "No."</p> <p>During a review of Resident 1's medical record on 3/23/10, there was no evidence that Nurses' Notes were entered for the period 3/18/10 to 3/23/10. When asked why these notes were missing, nursing staff indicated that they did not have time to complete them. A random review on 3/24/10 revealed that these Nurses' Notes still had not been entered into the medical record.</p> <p>Resident 1's roommates, Residents 2 and 3 were not interviewed due to cognitive deficits and inability to communicate the events of 3/22/10.</p>				

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	<p>Continued From page 9</p> <p>The Medical Examiner's Report received by the Department on 7/6/10, Case No. 2010-0294 indicated: " a] multiple contusions and abrasions about the nose, chin and anterior neck consistent with smothering-type injuries; b] conjuntival and oral mucosal petechial hemorrhages consistent with asphyxia; c] intramuscular tongue hemorrhage with urine and fecal incontinence suggestive of terminal hypoxic seizure; d] multiple bilateral strap muscle hemorrhages consistent with strangulation-type injuries; e] right hyoid fracture consistent with strangulation-type injury; f] bilateral thyroid cartilage fractures consistent with strangulation-type injuries; g] anterior chest and left breast contusion with right breast intraparenchymal hemorrhages. Cause of Death: Multiple Traumatic Injuries (Smothering, Strangulation, Blunt Force). Manner: Homicide."</p> <p>The facility failed to provide Resident 1 the right to be free from physical abuse when:</p> <ol style="list-style-type: none"> 1. the Administrator, Director of Nursing (DON), Director of Staff Development (DSD), LVN 1, and LVN 2 neglected to monitor, supervise and evaluate CNA 1's hiring, training, and orientation process. The administrative staffs were aware that CNA 1 had no related nursing experience specifically on the care of the elderly and 7 residents were assigned to his care on the first day of work. 2. the Director of Staff Development (DSD) failed to complete/document a Post Training 				

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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	
	<p>Continued From page 10</p> <p>Performance Evaluation to determine CNA 1's skills and competency in performing patient care.</p> <p>3. the facility did not develop a policy and procedure on Post Training Performance Evaluation.</p> <p>4. the licensed staff failed to conduct an orientation and direction to make sure that CNA 1 had knowledge of the individual needs of the 7 residents assigned to him.</p> <p>5. the Director of Nursing (DON) failed to acknowledge and act upon CNA 3's request to check on CNA 1 since it was a bathing day for the residents and that CNA 3 was not sure if CNA 1 was capable of doing the task for the 7 residents assigned to his care.</p> <p>The facility's systemic failure caused an immediate jeopardy on the 7 residents' health and safety. Resident 1 died due to suffocation when CNA 1 smothered her face with a pillow.</p> <p>The above violation presented an imminent danger to the patient, and was the direct and proximate cause of the death of the patient.</p>				

Event ID:G7M511

4/12/2011

10:24:16AM

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.