

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555020</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/29/2016</b>
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NAME OF PROVIDER OR SUPPLIER <b>LAGUNA HONDA HOSPITAL &amp; REHABILITATION CTR D/P SNF</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>375 Laguna Honda Blvd, San Francisco, CA 94116-1411 SAN FRANCISCO 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><b>CLASS AA CITATION – PATIENT CARE</b> 22-2788-0012588-F Complaint(s): CA00428248, CA00424710</p> <p>Representing the Department of Public Health: Surveyor ID # 33819</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><b>F323 483.25 (h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b> 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>This Requirement is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure an environment free of accident hazard and failed to provide adequate supervision for one of one sampled patient (Patient 1) when:</p> <p>A facility staff Certified Nurse Assistant (CNA 1) failed to implement a care plan requiring Patient 1 to be kept in line of sight while in his wheelchair and failed to lock both wheels of Patient 1's wheelchair during an off facility activity on 11/26/14.</p>		<p>This Plan of Correction is the response by Laguna Honda Hospital and Rehabilitation Center ("Laguna Honda" or "facility") as required by regulation, to the Statement of Deficiencies (Form CMS-2567) issued by the California Department of Public Health on December 23, 2016, and received by the facility on December 23, 2016, during an abbreviated standard survey for an entity reported incident number CA424710 and complaint number CA428248 that was initiated on January 28, 2015, and concluded on July 29, 2016. The submission of this Plan of Correction does not constitute an admission of the deficiency listed on this Form CMS-2567 or an admission to any statements, findings, facts, and conclusions that form the basis of the alleged deficiency.</p> <p>Laguna Honda is committed to providing a resident environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents.</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M. Valmor      TITLE: Chief Nursing Officer      (X6) DATE: 12/23/16

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 8

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.

State-2567 POC Accepted Alfredo Ubana 12/23/16      Page 1 of 8

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	<p>Before assisting Patient 1, into the facility vehicle, CNA 1 left Patient 1 on the curbside on an incline unsupervised, while CNA 1 returned to the front of the van to turn on the engine and the heater.</p> <p>This deficient practice resulted in Patient 1's fall when his wheelchair rolled down the incline towards the edge of the curb causing Patient 1 to fall face first onto the street directly behind the facility vehicle. Patient 1 sustained multiple injuries including a face laceration (a deep cut or tear in skin or flesh), hip fractures (a medical condition in which there is a break in the bone), and internal head bleeding. Patient 1 expired on 12/10/14 due to a traumatic brain injury from the fall.</p> <p>Findings:</p> <p>Patient 1 was admitted on 07/21/04 with diagnoses that included dementia (a general term for a decline in mental ability severe enough to interfere with daily life), neurogenic bladder (inability to drain urine due to nervous system) requiring indwelling bladder catheter (a tube to help drain urine), and diabetes (metabolic disease in which there are high blood sugar levels).</p> <p>Record review of the most recent comprehensive Minimum Data Set (an assessment tool) dated 02/14/14 indicated Patient 1 needed extensive assistance for activities of daily living like transfer and locomotion in unit. Patient 1 was not steady on his feet and only able to stabilize with staff assistance. Patient 1 used a wheelchair every day and ambulation was minimal.</p>		<p>The facility is also committed to enhancing the resident's quality of life by providing community outings that are safe and enjoyable.</p> <p>Staff are provided training upon hire and at a minimum, annually on accident prevention, resident supervision, and use of assistive devices when necessary. They are taught to be alert in identifying hazard(s) and risk(s) in the environment and to implement interventions to mitigate the risk of accidents and injuries.</p> <p>Nursing staff are taught to lock all the brakes of any type of chair or bed with wheels when transferring residents between surfaces and when residents are left in a stationary position.</p> <p>Resident 1 had resided at Laguna Honda since July 21, 2004. Record review of the last 3 years of Resident 1's Minimum Data Set show that Resident 1 did not have any fall incidents despite his risk for falls due to cognitive deficits and mobility problems.</p>	

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	<p>Record review of a Patient 1's facility form titled "Admission Nursing Assessment" dated 02/27/14, indicated he has history of falls, wandering/confusion/cognitive deficit has mobility or gait problems due to lower extremities weakness.</p> <p>Record review of Patient 1's "Activity Therapy Quarterly Note" dated 11/10/14 4:00 PM stated: "...The resident is very polite during daily activities...has maintained current level of participation. Resident needs daily reminders and assistance to and from daily on and off ward activities...attending community outings, restaurant, scenic outings and movies..."</p> <p>Record review of Patient 1's Interdisciplinary Team Meeting Note dated 11/19/14 stated under Discharge Plan "...24 hr. care and supervision secondary to functional limitations and cognitive impairments..."</p> <p>Record review of Patient 1's care plan dated 02/27/14, identified the problem of risk for falls related to mobility or gait problems, cognitive deficits, confusion, and or wandering, and medications. Another active care plan open on 6/20/14 and with a review date of 9/2014, for " At risk for easily bruising secondary to fragile skin, on aspirin therapy, tendency to slide down to the floor when in wheelchair ... ", indicated under "Date-Intervention: ...6/20/14 Line of sight to be provided when in wheelchair ...".</p> <p>On 01/28/15 at 10:30 am during an interview with</p>		<p>Resident 1 did not have a history of wandering or elopement as assessed on both Resident 1's Admission Nursing Assessment dated 02/27/14 and 02/09/12 as documented under the Behavioral/ Cognitive section of the form. A copy of the referenced documents was provided to the California Department of Public Health. Resident 1 was assessed safe to attend community outings by the Resident Care Team.</p> <p>Prior to the incident on 11/26/14, Resident 1 went on a variety of 6 outings including a City tour, to a pumpkin patch, a restaurant, the San Francisco Giants baseball game and to a movie on 1/31/14.</p> <p>Resident 1 was provided with immediate emergency treatment following the incident and treated at a General Acute Care Hospital from 11/26/14 to 12/3/14. Resident 1's conservator decided on palliative care for Resident 1 and the resident returned to the facility for end of life care and support on 12/3/2014.</p> <p>CNA1 had been working as a driver since November 2009. Following the incident CNA 1 was reassigned from driving duties.</p>	8/19/2016
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	<p>the Nurse Manager (NM) and the Nursing Director (ND), ND stated that Patient 1 had been part of a group outing on 11/26/14, a trip to a local theater to watch a movie. The group was composed of eight residents and three staff members including the driver. Upon exiting the theater, Patient 1 fell forward out of his wheelchair and sustained injuries that required transfer to an emergency room at a local General Acute Care Hospital (GACH 1). During the same interview, ND showed a copy of a diagram of the location where the incident occurred. It indicated there was a downhill slope from the theater door to the street loading zone. The diagram also indicated the two patients (Patients 1 and 2) were positioned on the side entrance of the bus but Patient 1 fell off the curb and was found at the back of the bus.</p> <p>During an interview with CNA 1 on 02/04/15 at 12:20 PM and with ND present, CNA 1 acknowledged driving the facility van to an outing with eight residents and three staff members including self. CNA 1 stated as the movie was ending, taking two wheelchair bound patients (Patient 1 and Patient 2) by himself to an elevator and out of the theater towards the curbside at the spot where the facility van was parked to assist the residents back into the facility vehicle. CNA 1 stated he stopped at the curbside at the front of the van passenger entrance door. CNA 1 demonstrated having been "in between the two wheelchairs and I locked the brakes like this..." (CNA 1 demonstrated locking one brake for each wheelchair, the left brake of Patient 2's wheelchair and the right lock of Patient 1's wheelchair). Asked if he locked only one</p>		<p>A review of the incident was conducted by a multi-disciplinary team. The following improvement opportunities were identified and activities carried out over several months:</p> <ol style="list-style-type: none"> <li>1. Nursing and Activity Therapy staff input were elicited through staff meetings to identify best practices for resident outings. Completed 1/12/15.</li> <li>2. In-service material was developed by Nursing Education on Prompt Accident Reporting and Investigation. Completed 1/12/15.</li> <li>3. Staffing Guidelines for Community Outings were developed. Completed 2/20/15.</li> <li>4. Other drivers were re-assessed on their competencies for their assigned duties. Completed 3/13/15.</li> <li>5. Bus drivers were assigned to report to the Activity Therapy Department instead of the Nursing Department. Completed 3/13/15.</li> <li>6. Cell phones were issued to staff who were assigned to go on community outings. Completed 3/16/15.</li> </ol>	

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	<p>wheel of each wheelchair, CNA 1 acknowledged this in the affirmative and added "...I don't know why...I know I should lock both wheels..." CNA 1 stated Patient 1 was closer to the back end of van.</p> <p>CNA 1 stated that he instructed Patient 1 and Patient 2 "stay here...", while CNA 1 was not looking at Resident 1, he turned and went into the vehicle to turn the engine on and the heater on. CNA 1 stated when he returned, only Patient 2 was at the curbside while Patient 1 was lying on the ground behind the van, bleeding from his face. CNA 1 stated he ran towards Patient 1 and lifted him off the ground stating "...I am sorry, I am sorry..." CNA 1 was asked for the location of Patient 1 wheelchair and how the transfer from the ground had taken place, CNA 1 stated "I don't remember...I have a mental block...", "I lifted him back to his wheelchair..."</p> <p>During an interview with CNA 1 on 02/04/15 at 12:30 PM and with ND present, Surveyor asked CNA 1 what he could have done to prevent this accident. In response, CNA 1 stated: "I would wait for my coworkers and stay with the patients, check for the (wheelchair) locks, not stop looking at the residents, not turn on the engine and heater if I am by myself with residents...not trust residents will follow my direction to 'stay here'..."</p> <p>Record review of an EMS Resident 1's report titled "Pre-Hospital Care Report" dated 11/26/14, stated: "Arrived at the scene to find patient (Patient 1) sitting in wheelchair with bleeding noted to the right side of head. Patient was waiting in wheelchair</p>		<p>7. An Outing Program Safety Guidebook was developed. Completed 4/23/15.</p> <p>8. An Outing Evaluation Form was developed to assess the areas of communication, loading and unloading procedures, seat belts, onsite review, and general Impression of the outing. Completed 4/1/15.</p> <p>9. The Activity Therapy Department policy and procedure on Community Outings were revised and transformed to a hospital-wide policy and procedure that included enhancements on the elements of resident safety. Completed 5/12/15.</p> <p>10. The Outing Evaluation Form was revised to include line of sight supervision need based on resident care plan.</p>	12/23/2016

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when the attendant looked away. Patient 1s wheelchair then rolled toward curb falling off curb face forward unto the ground..."

Record review of a 11/26/14 8:39 PM Patient 1's physician progress note stated under History of Present Illness (HPI): "Patient was reported out and about today when his wheelchair fell from the vehicle that he was riding in to the ground and he tipped over sustaining a head injury..."; and under Assessment and Plan: "Altered Mental Status - uncertain why he remains altered....head CT negative...However this does not exclude the possibility of slow subdural bleed after the fall...Will sent to [GACH 2] for further evaluation..."

Record review of Patient 1's facility integrated progress note on 11/26/14 indicated at 9:00 PM: "Resident still not fully awake. No verbal responding, only responds to painful stimulation with moving upper extremity, open eyes, mouth, but not talking. Resident's baseline mental status is verbally responding well". A 9:30 PM progress note stated: "Resident will be transferred to [GACH 2] to have further evaluation..." A 10:40 PM progress noted stated: " Resident was transferred to [GACH 2] for further evaluation due to altered mental status..."

Record review of Patient 1's facility form titled Inter Facility Transfer Record Nursing Information stated: " Resident (Patient 1) had a fall from wheelchair at 2 PM 11/26/14. Hit his head on the ground. Resident was sent out to hospital via 911....Hospital sent him back to facility, upon

Other residents who participate on bus outings will be assessed by the Resident Care Team for safety precautions and the level of supervision needed during outings. Identified safety and supervision needs will be communicated to outing escorts and the driver prior to each outing. Nurse Manager and Activity Therapy Supervisor are responsible for reviewing the Therapeutic Outing Planning Guide, Resident Assessment & Bag Lunch Request Form prior to each outing. Nursing Directors and the Activity Therapy Directors are responsible for monitoring compliance.

All residents will have their care plan reviewed for need of line of sight supervision. Line of sight supervision needs will be communicated to staff caring for the resident, within facility and during outings. Charge Nurses are responsible for monitoring compliance.

8/29/16 and on-going

1/03/2017 and on-going

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	<p>arrival resident mental status: stuporous (level of consciousness wherein a person is almost entirely unresponsive and only responds to base stimulation such as pain)...only respond to painful stimulation...had laceration of right forehead 4 sutures (stitches to hold body tissue together)... had abrasion of right elbow from fall...". Patient 1 was transferred to another hospital.</p> <p>Record review of a 12/03/14 GACH 2 Discharge Summary indicated from an abdomen and pelvis, and head Computerized Tomography (CT), (a computer processed X rays), that Patient 1 had sustained "Nondisplaced fractures of the right superior and inferior pubic ramus..." (A bone that forms part of the hip) and had "intraparenchymal hemorrhage..." and "Subarachnoid hemorrhage..." (Internal bleeding of the head).</p> <p>Record review of a death summary by physician MD 1, signed on 12/12/14 indicated that Resident 1 returned to the facility on 12/03/14 and stated under "Discharge Diagnosis: Traumatic brain injury from fall...". Patient 1 expired on 12/10/14 at 10:49 PM.</p> <p>Record review of a one page Autopsy Report dated 7/16/15 from the San Francisco Medical Examiner's Office, Case 2014-1157, stated: "Cause of death: Blunt force injuries of head."</p> <p>During a 9/8/15 4:30 PM telephone interview, the Director of Staff Development DSD, was asked regarding content of Certified Nurse Assistants in-services on wheelchair safety, and specifically the locking one or two resident's wheelchair brakes.</p>		<p>24/7 Nursing staff, Activity Therapy staff, and volunteers for bus trips or outings will complete training on standard of practice on use of wheelchairs, including transfer and transportation safety measures, identifying hazard(s) and risk(s), evaluating and analyzing hazard(s) and risk(s), implementing interventions to reduce hazard(s) and risk(s), monitoring effectiveness and modifying interventions when necessary, through vignettes reviews of PowerPoint slides on "Accident Prevention and Supervision During Community Outings." The Nurse Educator is responsible for developing the educational slides. Nurse Managers and Activity Therapy Supervisors are responsible for monitoring staff compliance with review of the instructional material.</p> <p>24/7 Nursing staff, Activity Therapy staff, and volunteers will complete training on implementing resident care plan particularly need for line of sight supervision within the facility and during outings. The Nurse Educator is responsible for developing the educational slides. Nurse Managers and Activity Therapy Supervisors are responsible for monitoring staff compliance with review of the instructional material.</p>	<p>8/29/16</p> <p>1/3/2017</p>

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	<p>DSD stated: "Of course we teach CNAs to lock both brakes."</p> <p>During a 1/22/16 8:50 AM follow-up telephone interview DSD stated: "We orient CNAs for two weeks, we give out documents with pictures, and ask for a return demonstration to make sure they lock both wheelchair brakes. The Physical Therapy Department was consulted in the development of this educational material. We revised it last in 2007..."</p> <p>Review of photographs taken by the surveyor dated 7/21/16 at 2:24pm of the sidewalk outside the movie theater where the incident occurred, indicated, there was a downhill incline from the theater to the street.</p> <p>Therefore, the facility failed to ensure an environment free of accident hazard and failed to provide adequate supervision for one of one sampled patient (Patient 1) when: A facility staff Certified Nurse Assistant (CNA 1) failed to lock both wheels of Patient 1's wheelchair when he parked the wheelchair on an incline curbside during an off- facility activity on 11/26/14. The facility failed to implement the care to provide supervision to keep Patient 1 in line of sight while in his wheelchair during an offsite facility activity on 11/26/14. CNA 1 left Patient 1 on the curbside while he returned to the van to turn on the engine and the heater.</p> <p>The deficient practice presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result and was a direct proximate cause of the death of the patient.</p>		<p>Quality Assurance (QA) reviews on resident outings will be completed by certified nursing assistant(s), activity therapist(s), volunteer(s), and the drive. The QA covers the following – periods: 1. Prior to leaving Laguna Honda, 2. During the outing, 3. Upon return to LHH to ensure that care plan was implanted. Nurse Managers are responsible for monitoring compliance with Resident Outing QAs. The Outing QAs were initiated the week of August 29, 2016. Results of the Resident Outing QA will be aggregated quarterly and reported to NQIC quarterly, and bi-annually to the Skilled Nursing Facility (SNF) Performance Improvement and Patient Safety (PIPS) Committee. Nurse Supervisors are responsible for reporting compliance to NQIC and Chief Nursing Officer is responsible for reporting compliance to the SNF PIPS Committee.</p>	<p>8/29/16 and on-going</p>

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