State of California - Health and Human Services Agency LA

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 91-2274-0005948-S

Date: 03/11/2009 Time: 1:55pm

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Type of Visit :
Incident/Complaint No.(s) : CA00124535

READ -ML
ENTD 4/13/09

Licensee Name: GRANCARE, LLC
Address: ONE RAVINIA DRIVE, SUITE 1250 ATLANTA, GA 30346
License Number: 910000154 Type of Ownership: Limited Liability Company

Facility Name: ARBOR VIEW REHABILITATION AND WELLNESS CENTER
Address: 1338 20TH STREET SANTA MONICA, CA 90404
Telephone: (310)255-2800
Facility Type: Skilled Nursing Facility Capacity: 144
Facility ID: 910000336

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $1,000.00	DEADLINE FOR COMPLIANCE 3/11/09 5:00 p.m.
72315(f)(7)	**CLASS B CITATION -- PATIENT CARE**		

72315. Nursing Service - Patient Care

(f) Each patient shall be given care to prevent formation and progression of decubiti, contractures and deformities. Such care shall include:

(7) Carrying out of physician's orders for treatment of decubitus ulcers. The facility shall notify the physician, when a decubitus ulcer first occurs, as well as when treatment is not effective, and shall document such notification as required in Section 72311(b).

Based on interviews and record review, the facility's staff failed to provide care and prevent the progression of a decubitus ulcer for Patient 1 by not notifying the physician of Registered Dietician's (RD) recommendation when a high protein nutrition needed to be added to promote healing. Patient 1 was admitted to the facility with a stage IV decubitus ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. {National Pressure Ulcer Advisory Panel (NPUAP) http://www.npuap.org/pr2.htm) The RD recommended a high protein nutrition to promote wound healing. The RD's recommendation was not implemented hence Patient 1's decubitus ulcer increased in size {5.5 centimeters (cm) in length, 7 cm in width, and 0.6 cm in depth; to 6 cm in length, 7 cm in width, and 1.5 cm in depth} within 23 days. The decubitis ulcer developed yellowish exudates, a foul odor, became infected, and required a surgical flap. Patient 1 was admitted to the acute care hospital for an infected stage IV decubitus ulcer and

Name of Evaluator:
Edgar Solis
HFEN

Evaluator Signature : [signature] HFEN

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature : [signature]
Name : Rebecca FORREST
Title : administrator

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	post-osteomyelitis (bone infection) of the wound area. Upon admission to the acute care hospital, Patient 1's albumin level was 2.6 grams/deciliter (g/dl) (normal 3.7-5.1 g/dl.) The facility failed to follow the registered dieticians recommendations, assess lab work, and obtain accurate assessments. Patient 1's nutritional status was not optimized for effective care to prevent progression of decubiti. Patient 1 was transferred to an acute care hospital for evaluation and treatment of an infected pressure ulcer, underwent surgery, received I.V. antibiotics, pain management, and required an intensive care unit admission. The Department received a Suspected Dependent Adult/Elder Abuse report on August 27, 2007. The report indicated Patient 1 was brought in by ambulance to the acute care hospital's emergency room and admitted for evaluation and treatment of a stage IV decubitus ulcer. On February 24, 2009 at 9:30 a.m., an unannounced visit was made to the facility to investigate a quality of care complaint A review of closed clinical record (facesheet) indicated Patient 1 was a 72-year-old female admitted to the facility on July 31, 2007. Admission diagnoses included renal/ureter (kidney) disorder, pneumonia, and decubitus (pressure) ulcer. A review of a MDS (Minimum Data Set) dated July 31, 2007, indicated Patient 1 was totally dependent on staff to move, turn side to side, and position her body while in bed. The MDS also indicated Patient 1 had full loss of voluntary movement of her arm, hand, and foot on one side of her body. Patient 1 was incontinent of bowel and required an indwelling catheter for urinary incontinence and management of decubitus ulcers. A review of the "Weekly Pressure Ulcer Record" indicated on August 1, 2007, the sacral (tailbone) pressure ulcer measured 5.5 centimeters (cm) in length, 7 cm in width, and 0.6 cm in depth with serosanguinous exudates and no odor was present. A review of the "Medical Nutritional Therapy Review" dated August 2, 2007, indicated supplemental formula with high protein nutrition was recommended and Staff E (RD 1) documented there was no new labs. The albumin level section was left blank. According to the "Braden Scale-For Predicting Pressure Sore Risk" dated July 31, 2007, Patient 1 was at mild risk for pressure sore. Further review revealed a Braden scale assessment was not conducted for dates August 7, 2007 and August 14, 2007, as

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	indicated on the facility's policy and procedure. During an interview conducted on February 27, 2009 at 10:50 a.m., Staff D stated the patient's skin was assessed and risk for pressure ulcers was documented on the Braden scale sheet on admission and quarterly thereafter. Additionally, she indicated the RD screens all patient admissions for stage III and IV pressure ulcers. She stated the RD then conducts an assessment and makes recommendations based on her professional opinion. Staff D stated if a patient was admitted to the facility with a pressure ulcer the Braden scale should have indicated the Patient was a high risk for pressure sore development. According to the facility's policy and procedure titled Skin Care Management dated December 12, 2005, indicated patients are reviewed on admission for their risk for development of pressure ulcers. Additionally, patients are screened weekly thereafter for three weeks (totaling 4 weeks), using the Braden Scale. The policy and procedure further indicated, under-nutrition, malnutrition, serum albumin below 3.4 grams per deciliter (g/dl), and hemoglobin less than 12 milligrams per deciliter are risk factors for pressure ulcer development. During an interview on February 27, 2007 at 11:05 a.m., Staff F (RD 2) indicated albumin levels and hemoglobin and hematocrit (H&H), which are a patient's blood count, are important laboratory assessments for promotion of wound healing, and an accurate nutritional assessment. She stated if a patient's albumin was low she would recommend a dietary protein supplement. Staff F stated an accurate record of oral intake was a must for an assessment of a patient's nutritional status. However, a review of the Patient 1's "Meal Intake Record" indicated many blank spaces where food intake percentages were supposed to be documented. Out of 21 days, six entries for breakfast; six entries for lunch; and fifteen entries for dinner were not documented. A review of the facility's policy and procedure titled, Calculating and Recording Nutritional Intake dated January 2006, indicated the Certified Nursing Assistant (CNA) documents the patient's intake after every meal and it was the licensed nurse's responsibility to ensure the documentation was done accurately and daily in a timely basis. A further review of Patient 1's closed clinical record indicated there was no evidence of

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

an albumin level, Patient 1's hemoglobin was 9.8 g/dl (normal 12-16 g/dl)/ hematocrit was 31.4% (normal 37-47%) on August 13, 2007 and lower on August 20, 2007 at 8.8 g/dl and 28.0%.

According to the National Pressure Ulcer Advisory Panel (NPUAP), interventions that influence decubitus ulcer healing include identifying malnutrition (via weight loss and laboratory data) and nutritional supplementation (consisting of protein, minerals, and vitamins).

According to the facility's policy and procedure dated January 2006, titled Nutritional Guidelines for Implementing Medical Nutrition Therapy Recommendations, indicated recommendations from the dietetic professional will be implemented and the reason for non-implementation or physician disagreement would be documented in the nurse's and nutrition's progress notes.

During an interview conducted on February 27, 2007 at 10:55 a.m., the Staff D indicated that she, the DON, or the nurse supervisor would follow up the RD's recommendation. She further stated the RD's recommendation and physician notification of the recommendation should be documented in the nurse's notes.

Further review of Patient 1's clinical record revealed no documented evidence that the physician was notified, no evidence of physician refusal, and no evidence of the nurse's acknowledgement of the RD's recommendations.

A review of Patient 1's "Weekly Pressure Ulcer Record" dated August 23, 2007 indicated the sacral ulcer measurements had increased to 6 cm in length, 7 cm in width, and 1.5 cm in depth 23 days after admission. Further review indicated exudates was yellowish in color, a foul odor was present and the physician was notified of the change in condition in regards to the wound.

A review of a nurse's note dated August 23, 2007 at 1 p.m., indicated Patient 1's pressure ulcer increased in size, drainage increased in amount, and pain was present at the ulcer site. The physician was notified. At 2:15 p.m., the note indicated the physician ordered Patient 1 to be transferred to an acute care hospital for pressure sore evaluation.

A review of the acute hospital consultation note dated October 3, 2007, indicated Patient 1 was admitted to the acute care hospital for an infected stage IV decubitus

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	ulcer and post-osteomyelitis (bone infection) of the wound area. A review of the a record titled Physician Progress Record revealed a photograph (dated August 23) of Patient 1's sacral decubitus ulcer and illustrates the severity and intensity of the wound. According to a hospital record dated August 24, 2007, Patient 1's hemoglobin was 8.3 g/dl (11.5-14.6 g/dl) and her albumin level was 2.6 g/dl (3.7-5.1 g/dl). A review of a culture and sensitivity report dated August 27, 2007 indicated Patient 1's wound was infected with two different organisms (proteus mirabilis and corynebacterium species) and subsequently required I.V. antibiotics of Vancomycin and Imipenem. Patient 1 underwent debridement and flap surgery of the pressure ulcer on September 7, 2007. Additionally, the record indicated, during Patient 1's acute hospital stay she developed sepsis (systemic blood infection) and was transferred to the intensive care unit and later expired on October 11, 2007. The facility's failure to follow the RD's recommendations, accurately assess Patient 1's nutritional status, and provide care to prevent the progression of her pressure ulcer had a direct relationship to the health and safety of Patient 1.

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE