

LA

SECTION 1424 NOTICE

CITATION NUMBER: 91-2267-0005955-S

Date: 03/13/2009 Time: 10:55 P.M.

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) : CA00135844

Confirmation - 12:55 PM LA

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

UC
LNTD-4/13/09

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

Table with 4 columns: SECTIONS VIOLATED, CLASS AND NATURE OF VIOLATIONS, PENALTY ASSESSMENT, DEADLINE FOR COMPLIANCE. Row 1: 72315(f)(47), CLASS B CITATION -- PATIENT CARE, \$1,000.00, 3/13/09 5:00 p.m.

Name of Evaluator: Leona Anderson HFEN
Evaluator Signature: Leona Anderson HFEN

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE
Signature: Bob Eskew
Name: BOB L. ESKEW
Title: RVPD

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

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SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	<p style="text-align: right;"><i>confirmation of time 12:55 pm</i></p> <p>A record review on February 27, 2007, indicated that on December 22, 2007, Patient 3 was transferred from the facility to an acute care hospital. The hospital identified Patient 3 to have a stage IV decubitus measuring, 4 centimeter (cm) by 4 cm on the patient's coccyx with tunneling and eschar. There were also two decubiti measuring 2cm by 2 cm one on the patient's right hip with granulation and tunneling and another on the patient's left hip with granulation.</p> <p>During a record review on February 27, 2007, Patient 3's face sheet indicated the patient was a 70 year-old male initially admitted to the facility on October 1, 2005 with a history of multiple hospitalizations. His diagnoses included cerebral vascular disease, dysphagia, osteoporosis, and diabetes mellitus. According to the clinical record, Patient 3 had a history of decubitus ulcers.</p> <p>A review of Patient 3's Minimum Data Set (MDS) full assessment dated July 10, 2007 and quarterly MDS dated January 10, 2007, April 10, 2007, and October 10, 2007, indicated Patient 3 was totally dependent on staff to perform all care, including transferring, bathing, bed mobility, personal hygiene, and toileting. The patient had memory problems, and was severely impaired to make decisions, and rarely or never understood others. The October 10, 2007 MDS, under section M1 and M2, indicated Patient 3 had a stage II decubitus ulcer.</p> <p>A review of a Braden Scale, (predicting Pressure Sore Risk) entry dated November 14, 2007, indicated Patient 3 had a score of 11 and a score of 12 or less represented "HIGH RISK" for decubitus. The "Patient Data Collection" and Nurse's Notes dated November 14, 2007, indicated Patient 3 had no open wounds. The right great trochanter area, the bilateral gluteal folds, and the right lower extremity decubitus wounds were healed and closed.</p> <p>Patient 3's Weekly Pressure Ulcer Record initiated on November 16, 2007, indicated a hospital -acquired (acute care) stage I sacral area skin breakdown, with no recorded measurement and 100 percent granulation. On November 23, 2007, the stage I decubitus had progressed to a 12 cm by 7 cm stage II. On December 11, 2007, the size diminished to 4 cm by 7 cm stage II with minimal sero-sanguineous exudates, ten percent granulation. On December 17, 2007, five days prior to Patient 3's transferring to the hospital the patient's decubitus had increased to a stage III and measured 7 cm by 10.5 cm with moderate yellow sero-sanguineous exudates and had 80 percent sloughing and undermining (utd), the surrounding skin was erythematous during all</p>

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	<p>recorded stages. The narrative note of the Weekly Pressure Ulcer Record dated December 17, 2007, indicated the patient's physician was notified of the wound, but there was no documentation that Patient 3's family was notified. The physician ordered wound care and an airbed. The unsigned physician telephone orders dated December 17, 2007, included a low air loss mattress for wound management when available. A review of the Treatment Record dated December 2007, indicated there was no documentation an air loss mattress was in place for 17 days, from December 5 - 22, 2007.</p> <p>A review of an incomplete Unavoidable Pressure Ulcer Worksheet dated November 16, 2007, indicated Patient 3 had an area was discovered on re-admission to the facility from the acute hospital of a stage I sacral decubitus ulcer. The laboratory result dated November 19, 2007; indicated Patient 3's albumin level was 2.3 Gram/deciliter (g/dl) with a reference range of 3.4 - 4.8 g/dl. However, the registered dietician (RD) assessments dated November 17, 2007, November 28, 2007, and December 21, 2007, did not recommend any changes in Patient 3's gastric tube feeding of Glucerna 75 cubic centimeter (cc) per hour for 20 hours and 150 cc water every shift plus 50 cc water with medication. There were no other recommendations by the RD for laboratory work, although there was a progression of Patient 3's decubitus ulcer.</p> <p>Patient 3 was transferred to an acute hospital on December 22, 2007, for shortness of breath, high blood pressure, and pneumonia. A review of the acute hospital history and physical dated December 22, 2007, indicated Patient 3 had a sacral decubitus with eschar (not able to stage). The hospital's progress notes dated December 22 and 23, 2007, indicated Patient 3 had a stage IV sacral decubitus ulcer. A nutrition assessment by the hospital's RD, dated December 23, 2007, indicated Patient 3 had a stage IV weeping ulcer. The RD's note indicated Patient 3's albumin level was 1.7 g/dl. The RD's note indicated the patient had severe visceral protein depletion and the current tube feeding was not meeting the needs of Patient 3.</p> <p>The acute hospital's nursing skin assessment dated December 22, 2007, indicated Patient 3 had a stage IV, coccyx decubitus measuring 4 cm. by 4 cm. with tunneling and eschar and an un-staged decubitus measuring 2 cm. by 2 cm. both on the right and left hip with granulation and tunneling. A review of a culture and sensitivity collected on December 22, 2007, of the patient's sacral decubitus ulcer, identified abundant gram-negative bacilli, gram-positive cocci in pairs and chains, and moderate yeast with pseudohyphae.</p>

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	<p>On February 27, 2009 at 10:25 a.m., during an interview, Staff D was questioned about nutrition screenings and indicated that after a request for a nutritional evaluation the dietician would review the clinical record and make written recommendations, which are passed on to the nursing staff and then to the physician for approval and orders. Staff D stated that pre-albumin testing was usually done when a patient had a stage III or IV decubitus; the dietician or treatment nurse does the recommendation for the pre-albumin test. On February 27, 2009, during an interview, Staff F stated the practice is to assess the patient for zinc, vitamin C, and protein levels, in addition to the albumin, pre-albumin, and hemoglobin and hematocrit.</p> <p>A policy and procedure titled "Pressure Ulcer Preventative Measures Policy" dated March 2000, indicated residents at risk for the development of pressure ulcers (scores of 16 or less on the "Risk for Pressure Ulcer" section of the Resident Data Set (Brigg #FMAR103HH) receive intervention to reduce the risk of pressure ulcers. The procedure stipulated among the list at number 22 the use of a pressure reducing mattress, and to avoid using an inner spring mattress.</p> <p>Failure of the facility to follow the physician's order in providing a pressure-relieving device and provide care to prevent the formation and progression of Patient 3's stage IV sacral pressure ulcer had a direct relationship to health, and safety of Patient 3.</p>

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