State of California

Memorandum

Department of Justice
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To: Ron Brown, Administrator
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Date: April 6, 2012

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From: Operation Guardians
Bureau of Medi-Cal Fraud and Elder Abuse - Sacramento
Office of the Attorney General

Subject: Operation Guardians Inspection

The Operation Guardians team conducted a surprise inspection of Yuba Skilled Nursing Center in Yuba City, on February 21, 2012. The following summary is based upon the team's observations, plus documents and information provided by the facility.

SUMMARY OF RESIDENT CARE FINDINGS:

1. The review of the medical chart for Resident 11-08-01 indicated the resident's original date of admission to the facility was 11/28/11 for rehabilitation following a fractured femur. The current nurse's notes reported the resident had just been re-admitted to the facility on 1/18/12 but it was not clear why the resident had been hospitalized. The "Nursing History and Admission Notes," completed by the nurse on 1/18/12, indicated the resident's diagnosis was "left femur fracture." The team nurse reviewed the Admission Face Sheet and determined the form had not been updated by the facility since readmission with any new diagnosis. The team nurse then reviewed the Care Plan and found there were no new concerns/problems other than identifying the resident's previous medical diagnosis from the Face Sheet. The team nurse was able to locate a physician's progress note dated 1/15/12. This note indicated the resident was admitted to the hospital to rule out **AMS**- an acronym that is not familiar to the team, but might be interpreted as **altered mental status**? The note also indicated the resident was positive for a urinary tract infection (UTI) and a cerebral vascular accident (CVA) had been ruled out. It was unclear from the facility's new admission documentation what acute symptoms the resident was having prior to her hospitalization. Due to the facility's inadequate documentation, the team could not determine if the resident was receiving the appropriate nursing care to meet her health care needs.

   Additionally, the treatment authorization record (TAR) stated the resident had a thigh wound from the original hip surgery and the physician ordered wound care twice a day (BID). According to the February, 2012 TAR, the resident had only received **BID treatments nine (9) days during 2/1/12- 2/21/12.** The physician had ordered the nurses to monitor the left thigh wound daily for signs and symptoms of infection. **The monitoring was not completed by the nurses on 2/2, 2/5, 2/12, 2/14 and 2/18. No wound care or assessment for signs and symptoms of infection were completed on 2/20/12.** According to the TAR, the resident was also **not** receiving skin treatment as ordered **every shift** to a *"non-blanchable"* area on the buttocks. This failure of nursing care was evident by the missing nursing initials/blank areas on the TAR form.

Because of the lack of documentation, it appears the facility nurses were not appropriately assessing the resident's previous facility medical chart, and reviewing the information received from the hospital to accurately implement an appropriate care plan when the resident was returned to the facility. This lack of documentation and continuity of care can jeopardize the resident's quality of care. The team's nursing review revealed an absence of wound care, wound monitoring, and skin treatment by the facility's nursing staff. These are situations that may indicate possible neglect.

2. Resident 11-08-02 was observed lying in bed and appeared to have contractures to the left arm, wrist and hand. There was no splint applied to the arm or roll cloth inside the palm of the hand. Review of the resident's medical chart showed the resident was admitted to the facility on 1/18/08 with a Cerebral Infarction. A secondary diagnosis on 7/15/10 indicated the resident had hemiplegia/hemiparesis. There was no documentation in the resident's Care Plan showing a plan had been implemented to prevent the development of contractures. There was no physician order for rehabilitation, or for the resident to receive the rehabilitation nursing assistant program. Therefore, review of the chart revealed the resident had developed the contractures at the facility but there was no plan in place to prevent this condition from occurring or for treatment.

   The "Physician Order For Life Sustaining Treatment" POLST - was signed by the resident's brother and the resident was a *"do not resuscitate"* (DNR). The team could not find any documentation that the brother had any legal authority to sign the POLST form. According to the admission document in 2008, the resident was his own responsible person. There was no diagnosis on the FACE sheet stating the resident lacked capacity. According to the chart documentation as reviewed, this resident's brother did not have the legal authority to sign this resident's POLST form.

   The FACE sheet also indicated the resident was a US Army Veteran. There was no documentation in the chart the resident had been connected to any Veteran services.

3. Documentation presented by the facility indicated there was a high incidence of resident falls, with the same residents falling multiple times. Upon further review, it appears nursing staff were not implementing appropriate fall prevention plans for these residents. Care plans were not appropriately written to address these issues. Many of the residents were being transferred repeatedly to the hospital for falls that may have been preventable. Additionally, many falls were not recorded on the incident/accident logs.

4. Review of the residents' Treatment Authorization Records (TARs) and wound care logs, showed the facility had a high incidence of acquired pressure ulcers. By reviewing the wound care log, it was noted that wounds were identified as being on residents' sacrum, coccyx, heels, ear lobes, and trochanters.

5. The residents appeared unkept. Residents were observed with worn and soiled clothing. Male and female residents appeared to be in need of basic grooming and bathing. These are residents' rights and personal hygiene issues.

6. Many residents were observed with their water receptacles out of reach. This can place the resident at risk for dehydration.

FACILITY ENVIRONMENTAL OBSERVATIONS:

1. During the walk-through of the building, the OG team observed maintenance and structural issues. Areas of concern included decomposing walls at the floor level, uneven floor surfaces, peeling paint throughout the facility, non-functioning water fountains, and heavily soiled floors, baseboards and doors. It appeared the long-term care area of the building needed far more work than the rehabilitation section.

2. Resident call lights were observed to be illuminated for extended periods of time before the facility staff attended to the resident's needs.

5. Several resident rooms did not have the name of the resident on the door. These residents had been residing at the facility for several weeks. This is a safety issue. It is necessary for facility staff to accurately identify the residents and residents need to be able to locate their room.

6. The water fountains located by the kitchen and Central Supply Room were not functioning. This does not allow the residents to maintain hydration as needed. The water fountain located by the kitchen was soiled with a tan colored thick substance.

7. Unmarked urinals and pink basins were observed in resident rooms throughout the facility. This is a health and safety issue, as well as an infection control issue.

8. The resident residing in Room 304 C had the head of his bed positioned directly against the peeling paint on the wall. This could be a health hazard.

9. The shower room located across from Central Supply was observed with mold and feces (brown substance) on the floor. The shower room located by the Rehabilitation Department was also observed with a soiled floor. And the linen closet loated by Room 308 had a heavily soiled floor.

ADMINISTRATIVE OBSERVATIONS:

1. It appeared that the facility's procedure is to close residents' charts when a resident is transferred to the hospital. The residents would return within the bed-hold time period, but the facility would complete all the admission paperwork again, along with the other necessary disciplines to repeat their assessments. This practice seemed to be a time consuming procedure, thus taking time away from resident care and possibly jeopardizing the continuity of care for the resident.

2. The team's observations of the facility's activities were that they were not structured to benefit all residents' needs. The only activity observed during the team's inspection time was "coloring in books" which was only attended by approximately seven residents. Several residents were observed in need of constant redirection by the staff as they were not engaged in the activity.

STAFFING:

Based on the records provided by the facility, staffing levels were not compliant with the 3.2 hours per resident day (hprd) on **two of the six** days randomly reviewed. **The average hprd was 3.34 hours.** Providing the minimum required number of nursing hours is not always adequate to guarantee a quality level of care for the residents. The team was concerned with the amount of staffing hours, considering the high incidence of acquired pressure ulcers and the resident falls.

CONCLUSION:

Please be advised that this is a summary of information available to us at this time. Should further information develop from the efforts of Operation Guardians, we will notify you at the appropriate time.

The Operation Guardians inspection does not preclude any Department of Health Services complaint or annual visits, any law enforcement investigation or other licensing agency investigation or inspections, which may occur in the future. A copy of this report is being forwarded as a complaint to the Department of Health Services. This inspection does not preclude any further Operation Guardians unannounced inspection.

We do not require that you submit a plan of correction regarding the findings of the Operation Guardians inspection. However, at some future time, the contents of this letter may be released to the public.

We encourage your comments so they can be part of the public record as well. If you have any questions or any comments, please contact Cathy Long NEII, at 1425 River Park Drive, Sacramento, California 95815, phone: (916) 274-2913 or Peggy Osborn at (916) 263-2505.