State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 030015623

Date: 12/23/2019 12:00:00 AM

Type Of Visit: Complaint Investig.

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

Incident/Complaint No.(s) : CA00648877

Licensee Name: GGNSC Stockton LP

Address: Four Embarcadero Center, Suite 710 San Francisco, CA 94111

License Number: 100000051 Type of Ownership: Partnership

Facility Name: Stockton Nursing Center

Address: 4545 Shelley Court Stockton, CA 95207

Telephone : (209) 477-0271

Facility Type: Skilled Nursing Facility Capacity: 119

Facility ID: 100000073

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT	DEADLINE FOR COMPLIANCE
	CLASS: AA CITATION: Patient Care	100000.00	1/3/2020

483.25(d)(1)(2)

CLASS AA **CITATION --** Patient Care

F689 Free of Accident Hazards/Supervision/Devices
Section 483.25(d) Accidents.
The facility must ensure that -
Section 483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and
Section 483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.

The following citation was written as a result of an unannounced visit to the facility on 8/5/19 for the investigation of facility reported incident #CA00648877.

As a result of the investigation the Department determined the facility failed to ensure Resident 1, known to be at risk for elopement, was provided direct supervision to prevent him from leaving the facility through an unsecured door, unaccompanied and without staff knowledge.

Name Of Evaluator:
Jason Rye
HFEN

Evaluator Signature:_____

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

Signature:_____

Name:_____

Title:_____

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

This failure resulted in Resident 1 leaving the facility unsupervised on 8/2/19. The Resident 1 was discovered dead the next morning (8/3/19) approximately 2 miles from the facility after having been hit by a train, which was the direct and proximate cause of death for Resident 1.

Review of Department Records revealed another resident eloped from the facility on 7/29/19 through the north-east exit of the facility. The investigation revealed that the door was not alarmed. This occurred four days prior to Resident 1 leaving the facility undetected.

A review of the Skilled Nursing Facility's (SNF) "Admission Record" for Resident 1, dated 8/1/19, indicated a history of dementia and traumatic brain injury (TBI). Review of the acute hospital document titled, "Discharge Planning Consult" undated, indicated a history of leaving his previous residence unsupervised. Resident 1 was admitted to the SNF on 8/1/19.

A review of section G of Resident 1's MDS (Minimum Data Set-an assessment tool), dated 8/2/19, indicated the resident required supervision.

A review of the history and physical from the acute hospital, dated 6/18/19, indicated a diagnosis of "Worsening impulsive behavior..." The report further indicated Resident 1 had unpredictable wandering which posed a significant risk of unintentional self-harm. The hospital's discharge plan was for Resident 1 to be discharged to a locked facility.

A review of the SNF's Baseline Care Plan and Wandering Assessment performed 8/1/19 indicated Resident 1 was at "High risk for wandering" and was, "An elopement risk (increased risk of leaving the facility without staff knowledge)."

A review of SNF Progress notes for Resident 1, dated 8/2/19 at 3:55 a.m., indicated "Wanders in and out of unit at the beginning of the shift, redirected resident..."

In an interview with the Administrator (ADM) on 8/5/19 at 4:30 p.m., the ADM stated Resident 1 was admitted to the facility on 8/1/19. On 8/2/19, Resident 1 was last seen by staff at approximately 8:30 p.m. Resident 1 left the facility and the search for Resident 1 was unsuccessful. On 8/3/19, Resident 1 was found dead, approximately 2 miles from the facility after being struck by a train. The ADM confirmed the facility is not a locked building.

In an interview with Licensed Nurse 1 (LN1) on 8/5/19 at 5 p.m., LN1 stated Resident 1 was at a high risk for elopement due to his ability to walk without assistance, a previous history of elopement, and confusion. LN1 further stated that on 8/1/19 Resident 1 was wandering throughout the facility and required redirection several times.

In an interview with Certified Nursing Assistant 1 (CNA1) on 8/5/19 at 5:20 p.m., CNA1 stated Resident 1 was able to walk on his own without assistance and, due to his confusion, required redirecting. CNA1 further stated she saw Resident 1 attempting to go outside the facility several times during the PM shift on 8/2/19.

In an interview with the Director of Nursing (DON) on 8/5/19 at 5:30 p.m., the DON stated,

"He should have had a staff member with him at all times until we got to know him better due to his mental status and physical ability."

In an interview with Certified Nursing Assistant 2 (CNA2) on 8/15/19 at 12:30 p.m., CNA2 stated on 8/1/19 Resident 1 was walking throughout the building and required redirecting several times during her shift.

In an interview with Licensed Nurse 2 (LN2) on 8/15/19 at 1 p.m., LN 2 stated she was working on the evening of 8/2/19 when Resident 1 eloped. LN2 further stated, Resident 1 was last seen at 8:30 p.m. At 9 p.m. the CNA reported to her, Resident 1 could not be found. The staff then searched the facility for the resident but he could not be found. After approximately 10 to 15 minutes, she notified the police, administrator, physician, and the resident's family.

In a concurrent video review and interview with the ADM on 8/22/19 at 10 a.m., video footage (no audio) taken by the facility on 8/2/19 and verified by the ADM, showed Resident 1 leaving the facility at 8:42 p.m., through the north-east exit door which was unattended and unsecured. According to the ADM, the door was locked at all times and required a code in order to exit the building. The door had opaque glass as well as an alarm code panel on the inside. Prior to exiting the facility, Resident 1 is seen pushing on the door, the door then opened and he walked out. At no point prior to eloping was Resident 1 seen attempting to use the code panel on the right side of the door. After Resident 1 left the facility, no staff were seen on video attempting to silence the alarm. The ADM further stated, "The alarm must not be working since no one comes to the door."

A review of a SNF "Physician's Progress Note" for Resident 1 dated 8/2/19, indicated, the Resident was "aggressive" and the Neudexta (a medication used to treat neurological disorders i.e.; aggression, wandering) was "not effective."

During an interview with the Psychiatrist (MD) on 9/16/19 at 1:30 p.m., the MD stated, Resident 1 was seen by him on the morning of 8/2/19. The MD further stated, Resident 1's behavior continued to be aggressive, so the Neudexta was stopped and Depakote (a medication used to treat certain psychiatric conditions) was started.

During an interview with the DON on 9/17/19 at 10 a.m., the DON stated, if the resident is exit seeking they are to have direct 1:1 supervision.

On 8/5/19 at 5:40 p.m., a request was made for the facility policy on direct 1:1 supervision. The DON stated, the facility did not have a policy on direct 1:1 supervision.

During an interview with Licensed Nurse 3 on 9/17/19 at 10:30 a.m., LN3 stated she was working day shift on 8/1/19 and Resident 1 had required redirection several times during her shift.

In an interview with the Director of Staff Development (DSD) on 9/17/19 at 11 a.m., the DSD stated it was her expectation for staff to place residents that are high risk of elopement on direct 1:1 supervision first, before advancing them to every 15 minute checks or every 30 minute checks.

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There was no documented evidence that Resident 1 was receiving direct supervision.

In an interview with the DSD on 9/18/19 at 9 a.m., the DSD stated, "The exits should be watched by staff at all times."

A review of the facility document titled, "Preventing Elopement" and undated, indicated; "Exits must be under visual supervision by designated associates."

During an interview with the ADM on 9/18/19 at 2:30 p.m., the ADM stated, in reference to the video recording from 8/2/19 at 8:42 p.m., "I didn't see him [Resident 1] use the key pad, he just opened the door and left." The ADM then stated, "The door should be alarming but it must not be working since none of the staff were seen attempting to silence the alarm." The ADM further stated, "The door must have been unlocked, because I didn't see him [Resident 1] reach over and use the key pad to unlock it."

In an interview with Licensed Nurse 4 (LN4) on 9/18/19 at 3 p.m., LN4 stated Resident 1 was exit seeking as evidenced by him exiting out the back door into a fenced area on 8/1/19. LN4 further stated if Residents are exit seeking, they should be on 1:1 (staff to resident continuous, direct supervision).

In a concurrent video review and interview with the ADM on 9/19/19 at 12 p.m., The ADM verified on 8/2/19 at 9:46 p.m., staff were seen walking into the building from the outside through the north-east entrance and no key was used. On 8/2/19 at 9:47 p.m., staff were seen walking out the door and no code was used. On 8/2/19 at 11:43 p.m., a resident in a wheelchair was seen going out the door and no code was used. A staff member then points to the top of the door. On 8/2/19 at 11:44 p.m., a staff member was seen jumping up and hit the top of the door.

During an interview with the ADM on 9/19/19 at 1 p.m., the ADM stated there was a switch above the north-east exit door that turned the alarm on and off. The ADM further stated he was, "Unsure why it was off."

A review of the Certificate of Death, issued 9/12/19, for Resident 1 indicated the cause of death was "multiple blunt force injuries" due to "pedestrian struck by a train".

Therefore, the Department determined the facility failed to ensure Resident 1, known to be at risk for elopement, was provided direct supervision to prevent him from leaving the facility through an unsecured door, unaccompanied and without staff knowledge.

This violation 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 Resident 1.

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