**SECTION 1424 NOTICE**

**CITATION NUMBER:** 12-2134-0013700-F

Date: 01/19/2018 Time: _____

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) : CA00551075, CA00550513

Licensee Name: Spruce Holdings, LLC

Address: 100 E. San Marcos Boulevard, Suite 200 San Marcos, CA 92069

License Number: 120000586 Type of Ownership: Limited Liability Company

Facility Name: REDWOOD SPRINGS HEALTHCARE CENTER
Address: 1925 E Houston Ave Visalia, CA 93292
Telephone:
Facility Type: Skilled Nursing Facility Capacity: 176
Facility ID: 120001469

| SECTIONS VIOLATED | CLASS AND NATURE OF VIOLATIONS | PENALTY ASSESSMENT $100,000.00 | DEADLINE FOR COMPLIANCE 2/5/18 12:00 a.m. |
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F323

**CLASS** AA **CITATION -- PATIENT CARE**

F323 CFR 483.25 (d) Accidents.

The facility must ensure that -
(1) The resident environment remains as free from accident hazards as is possible; and
(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

On 9/12/17, at 10 AM, an unannounced visit was made to the facility to investigate a complaint of patient injury. The Department determined the facility failed to provide adequate supervision to Patient 1 when she was left unattended while using the toilet. This resulted in a fall, head injury, and her subsequent death.

Patient 1 was an 81 year-old female, admitted to the facility on 3/1/17. She had diagnoses that included diseases of the heart, muscle weakness, difficulty in walking, difficulty in swallowing, and left-sided weakness due to a previous stroke (occurs when blood supply is cut off to the brain, and can result in paralysis or the loss of ability to move and/or feel a body part). Patient 1 had moderately impaired thinking ability and memory.

Name of Evaluator:
Carol Erickson
Health Fac Evaluator Sup

Evaluator Signature : M. Guzman. HFEN 1/19/18

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

Signature :

Name : SETH BRATHWAITE

Title : NA

**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 |
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During an interview on 9/12/17 at 8:05 AM, Family Member (FM) 1 stated Patient 1 was paralyzed on the left foot, arm, and leg. FM 1 stated that on 8/29/17, staff had left Patient 1 on a commode chair (a plastic chair on wheels which goes over the toilet) and "she must have fallen to the left" and sustained an injury to the left eye. Patient 1 was taken to the Emergency Room (ER), a CT scan (Computerized Tomography, a computer-assisted x-ray) was performed, and stitches (also known as sutures) placed on her left forehead. FM 1 stated when she called on Thursday morning (8/31/17), after she had returned to the facility, and the nurse said, "She's doing great." FM 1 stated, "My sister went in at 8 AM and found her not waking up and soaked in sweat and called me. I called the nurse and she went to the bedside. The nurse said 'she's probably tired from the fall.' My sister called me and said we need to get her back to hospital. The ER doctor told me the fall had caused her brain to shift [move] . . . now her brain is bleeding. The doctor said we might not see damage for the first few hours and this was the case. They [the facility] shouldn't have left her. They knew she couldn't sit up on her own. She would lean to her left." FM 1 stated Patient 1 had since died on 9/4/17, and that "makeup for the funeral didn't cover up the bruise" on her face.

During an interview with Licensed Vocational Nurse (LVN) 1 on 9/12/17, at 10:20 AM, she stated, "I wasn't there [when Patient 1 fell]. I saw CNAs [Certified Nursing Assistants] looking for a nurse. [Patient 1] was on the floor bleeding on the left side. [Patient 1] didn't remember what happened. She has left side paralysis. She was sitting on the commode chair above the toilet. The CNA was there and had turned around to pick up clothes."

During a concurrent interview and observation with Certified Nursing Assistant (CNA) 1 on 9/12/17, at 10:45 AM, she stated Patient 1 could not move her left side and "that day me and another CNA [CNA 2] grabbed her pants and put her on the toilet." CNA 1 stated CNA 2 left after Patient 1 was transferred to the toilet and was not present when the fall happened. CNA 1 stated she was going to get Patient 1's shirt out of her closet and "I didn't see what happened. It was so quick." CNA 1 demonstrated going to the closet to get the shirt and when the closet was opened, the patient was out of sight and out of reach of CNA 1.

During an interview on 9/12/17 at 11:15 AM, CNA 2 stated she had helped transfer Patient 1 and did not see the fall.

Patient 1's Minimum Data Set (MDS, a standardized, comprehensive assessment tool)

| SECTIONS VIOLATED | CLASS AND NATURE OF VIOLATIONS |
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| | dated 6/7/17, indicated a BIMS (Brief Interview for Mental Status which evaluates cognition, the ability to remember and think clearly) score of 9, which indicated moderately impaired cognition. The MDS indicated Patient 1 showed difficulty with short-term memory and required the extensive physical assistance of two persons for toilet use. The MDS stated Patient 1 required "two+ persons physical assist" for toilet use. Toilet use is defined in the MDS as "how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag." The instructions for the MDS toileting section indicated "Code for the least steady episode of moving on and off a toilet or portable commode, using an assistive device if applicable."<br><br>The MDS also indicated Patient 1 was "Not steady, only able to stabilize with staff assistance" regarding "Moving on and off toilet." The MDS indicated Patient 1 had a "Functional Limitation in Range of Motion," with "Impairment on one side" of her "Upper extremity (shoulder, elbow, wrist, hand)" and her "Lower extremity (hip, knee, ankle, foot)."<br><br>Patient 1's Care Plan, dated 3/9/17, stated she needed the assistance of "1-2 person" with toileting, related to a "decline in functional ADL [Activity of Daily Living] activity such as . . . toileting."<br><br>Patient 1's Progress Note dated 8/29/17, at 10:44 AM, written by LVN 1 indicated, "Resident [Patient 1, the terms 'patient' and 'resident' can be used interchangeably] was taken to bathroom by CNA on duty. Sat on shower chair, which was placed above the toilet. While CNA turn around to grab resident's clothes from the closet, which is right next to the bathroom, she heard a loud noise. The CNA turn around to check on the resident and resident was found on the floor bleeding from the left side of her eye. The CNA did not actually saw resident falling. Resident did not remember that she fell when asked." Patient 1's Progress Note dated 8/29/17 at 7 PM, written by LVN 1 indicated, "Resident return from [hospital] this evening with 8 stitches to skin tear to left side of eye due to [status post] fall. Slight bleeding noted to sight [sic]."<br><br>Patient 1's Progress Note dated 8/31/17, at 11:30 AM, by LVN 2 indicated, "RP [Responsible Party] requesting resident be sent to ER because she feels resident is alerted from her baseline." The Progress Note dated 8/31/17 at 5:59 PM written by LVN 2, indicated, "Resident is being admitted . . . for acute left subdural bleed [a life-threatening injury that occurs when blood vessels rupture between the brain and its |

| SECTIONS VIOLATED | CLASS AND NATURE OF VIOLATIONS |
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membranes and the blood presses on the brain tissue]."

During a review of the hospital's clinical record for Patient 1, the documentation titled Physician Documentation, dated 8/29/17, at 9:49 AM indicated, "81 year-old female on Eliquis [a medication that slows the blood's ability to clot] brought in by ambulance after a fall in which she hit her head on tile flooring and sustained a head laceration [cut]. The fall was unwitnessed and patient is unsure if she lost consciousness or not. But a thump was heard by staff at [the facility]. They ran in to help her and she was conscious." The physical exam indicated an 8 centimeter (3.14 inch) laceration to left upper forehead with active bleeding.

The Physician Documentation dated 8/31/17, at 12:19 PM indicated, "The patient is a 81 year-old female who present to the facility with a complaint of AMS [altered mental status]. The symptoms began this morning. . . Family states that patient was not acting herself this morning. . . Had CT done on 8/29/17 which came back normal. History of left sided deficits from previous stroke." The CT of the head report dated 8/31/17, at 12:28 PM indicated, "Compared to prior exam, there is interval development of left holohemispheric subdural hematoma [brain bleeding], measuring up to 1.2 centimeters in size. . . ." The Physician Documentation on 8/31/17, at 12:58 PM indicated, "There was an acute impairment of an organ system with high probability of imminent or life threatening deterioration in the patient's condition." Nursing Notes on 8/31/17, at 1 PM indicated the family did not want to transfer Patient 1 to another hospital and requested comfort care measures. Patient 1 died on 9/4/17.

The hospital document titled Death Summary, dated 10/2/17, indicated "This is an 81-year-old female, who was living at [facility] over the last 6 months. Apparently, she was on the bathroom commode and she fell and hit her head, and she was discharged back to [the facility]. Apparently, the CT at that time showed no acute findings; however, the patient became more and more lethargic [tired or sluggish] and was unable to hold on a conversation, so she was sent back to the emergency room, at which point, there was an interval development of a left-sided subdural hematoma measuring 1.2 centimeters [about 1/2 inch] with a mass effect [a life threatening condition where the hematoma presses against the brain] . . . comfort care measures were initiated given patient's very grave prognosis. Unfortunately, the patient's condition continued to decline and the patient died 9/04/2017."

Patient 1's Death Certificate, dated 9/14/17, stated her "Immediate Cause of Death" was "Respiratory Failure." The "UNDERLYING CAUSE (diseases or injury that initiated

| SECTIONS VIOLATED | CLASS AND NATURE OF VIOLATIONS |
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| | events resulting in death)" were "Acute Subdural Hematoma, Acute Closed Head Trauma."<br><br>During an observation on 9/19/17 at 10:20 AM, the commode chair was noted in a shower room. On the bottom of the chair was a sticker, which stated, "Patient must never be left unattended or unsupervised."<br><br>The facility failed to supervise Patient 1 while she was using the toilet. This a failure resulted in her falling and hitting her head on the floor, causing bleeding inside her skull. Patient 1 died six days later.<br><br>This failure presented imminent danger that death or serious harm would result or substantial probability that death or serious physical harm would result therefrom, and was a direct proximate cause of Patient 1's death. |

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055604 | A. BUILDING _____ B. WING _____ | 12/20/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| REDWOOD SPRINGS HEALTHCARE CENTER | 1925 E Houston Ave, Visalia, CA 93292-2345 TULARE COUNTY |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| | The following reflects the findings of the Department of Public Health during a Complaint Investigation visit:<br><br>CLASS AA CITATION -- PATIENT CARE<br>12-2134-0013700-F<br>Complaint(s): CA00551075, CA00550513<br><br>Representing the Department of Public Health:<br>Surveyor ID # 2134, Health Fac Evaluator Sup<br><br>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.<br><br>F323 CFR 483.25 (d) Accidents.<br>The facility must ensure that -<br>(1) The resident environment remains as free from accident hazards as is possible; and<br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>On 9/12/17, at 10 AM, an unannounced visit was made to the facility to investigate a complaint of patient injury. The Department determined the facility failed to provide adequate supervision to Patient 1 when she was left unattended while using the toilet. This resulted in a fall, head injury, and her subsequent death.<br><br>Patient 1 was an 81 year-old female, admitted to the facility on 3/1/17. She had diagnoses that included diseases of the heart, muscle weakness, difficulty in | | Preparation and/or execution of this Plan of Correction, inclusive of pages _1_ through _2_, does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by provisions of 42 CFR 483, et seq., and Health and Safety Code Section 1280. In response to the Department's findings we submit the following Plan of Correction which shall constitute Redwood Springs Care Center credible for allegation of compliance.<br><br>**F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES**<br><br>1. The Resident # 1 no longer resides in the facility.<br>2. The Director of Nursing (DON) reviewed the facility falls for the month of December on 12/27/2017. To ensure the facility staff provide adequate supervision and assistance to prevent falls with injury. No other residents were found to be affected by this deficient practice. | |

Event ID:I4UH11 1/19/2018 11:41:41AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE NHA (X6) DATE 1/19/18

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.

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| | 055604 | A. BUILDING _____ B. WING _____ | 12/20/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| REDWOOD SPRINGS HEALTHCARE CENTER | 1925 E Houston Ave, Visalia, CA 93292-2345 TULARE COUNTY |

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| | walking, difficulty in swallowing, and left-sided weakness due to a previous stroke (occurs when blood supply is cut off to the brain, and can result in paralysis or the loss of ability to move and/or feel a body part). Patient 1 had moderately impaired thinking ability and memory.<br><br>During an interview on 9/12/17 at 8:05 AM, Family Member (FM) 1 stated Patient 1 was paralyzed on the left foot, arm, and leg. FM 1 stated that on 8/29/17, staff had left Patient 1 on a commode chair (a plastic chair on wheels which goes over the toilet) and "she must have fallen to the left" and sustained an injury to the left eye. Patient 1 was taken to the Emergency Room (ER), a CT scan (Computerized Tomography, a computer-assisted x-ray) was performed, and stitches (also known as sutures) placed on her left forehead. FM 1 stated when she called on Thursday morning (8/31/17), after she had returned to the facility, and the nurse said, "She's doing great." FM 1 stated, "My sister went in at 8 AM and found her not waking up and soaked in sweat and called me. I called the nurse and she went to the bedside. The nurse said 'she's probably tired from the fall.' My sister called me and said we need to get her back to hospital. The ER doctor told me the fall had caused her brain to shift [move] . . . now her brain is bleeding. The doctor said we might not see damage for the first few hours and this was the case. They [the facility] shouldn't have left her. They knew she couldn't sit up on her own. She would lean to her left." FM 1 stated Patient 1 had since died on 9/4/17, and that "makeup for the funeral didn't cover up the bruise" on her face. | | 3. Education was provided to the Certified Nursing Assistants (C. N.A.) & LIcensed Nurses on Fall Prevention on 10/15/2017.<br>In-service will be provided to the certified nursing assistants and the licensed nurses regarding fall prevention on 1/10/2018.<br><br>4. The DON and/or designee will conduct weekly observations times three months of resident activities of daily living to ensure the residents receive adequate supervision and assistance to prevent falls with injury.<br>The findings will be reported to the Quality Assessment and Assurance Committee and further follow up action done until resolved.<br><br>Date Completed: 2/5/18 | |

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| | memory and required the extensive physical assistance of two persons for toilet use. The MDS stated Patient 1 required "two+ persons physical assist" for toilet use. Toilet use is defined in the MDS as "how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag." The instructions for the MDS toileting section indicated "Code for the least steady episode of moving on and off a toilet or portable commode, using an assistive device if applicable."<br><br>The MDS also indicated Patient 1 was "Not steady, only able to stabilize with staff assistance" regarding "Moving on and off toilet." The MDS indicated Patient 1 had a "Functional Limitation in Range of Motion," with "Impairment on one side" of her "Upper extremity (shoulder, elbow, wrist, hand)" and her "Lower extremity (hip, knee, ankle, foot)."<br><br>Patient 1's Care Plan, dated 3/9/17, stated she needed the assistance of "1-2 person" with toileting, related to a "decline in functional ADL [Activity of Daily Living] activity such as. . . toileting."<br><br>Patient 1's Progress Note dated 8/29/17, at 10:44 AM, written by LVN 1 indicated, "Resident [Patient 1, the terms 'patient' and 'resident' can be used interchangeably] was taken to bathroom by CNA on duty. Sat on shower chair, which was placed above the toilet. While CNA turn around to grab resident's clothes from the closet, which is right next to the | | | |

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| | bathroom, she heard a loud noise. The CNA turn around to check on the resident and resident was found on the floor bleeding from the left side of her eye. The CNA did not actually saw resident falling. Resident did not remember that she fell when asked." Patient 1's Progress Note dated 8/29/17 at 7 PM, written by LVN 1 indicated, "Resident return from [hospital] this evening with 8 stitches to skin tear to left side of eye due to [status post] fall. Slight bleeding noted to sight [sic]."<br><br>Patient 1's Progress Note dated 8/31/17, at 11:30 AM, by LVN 2 indicated, "RP [Responsible Party] requesting resident be sent to ER because she feels resident is alerted from her baseline." The Progress Note dated 8/31/17 at 5:59 PM written by LVN 2, indicated, "Resident is being admitted . . . for acute left subdural bleed [a life-threatening injury that occurs when blood vessels rupture between the brain and its membranes and the blood presses on the brain tissue]."<br><br>During a review of the hospital's clinical record for Patient 1, the documentation titled Physician Documentation, dated 8/29/17, at 9:49 AM indicated, "81 year-old female on Eliquis [a medication that slows the blood's ability to clot] brought in by ambulance after a fall in which she hit her head on tile flooring and sustained a head laceration [cut]. The fall was unwitnessed and patient is unsure if she lost consciousness or not. But a thump was heard by staff at [the facility]. They ran in to help her and she was conscious." The physical exam indicated an 8 centimeter (3.14 inch) laceration to left upper forehead with active | | | |

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| | bleeding.<br><br>The Physician Documentation dated 8/31/17, at 12:19 PM indicated, "The patient is a 81 year-old female who present to the facility with a complaint of AMS [altered mental status]. The symptoms began this morning. . . Family states that patient was not acting herself this morning. . . Had CT done on 8/29/17, which came back normal. History of left sided deficits from previous stroke." The CT of the head report dated 8/31/17, at 12:28 PM indicated, "Compared to prior exam, there is interval development of left holohemispheric subdural hematoma [brain bleeding], measuring up to 1.2 centimeters in size. . . ." The Physician Documentation on 8/31/17, at 12:58 PM indicated, "There was an acute impairment of an organ system with high probability of imminent or life threatening deterioration in the patient's condition." Nursing Notes on 8/31/17, at 1 PM indicated the family did not want to transfer Patient 1 to another hospital and requested comfort care measures. Patient 1 died on 9/4/17.<br><br>The hospital document titled Death Summary, dated 10/2/17, indicated "This is an 81-year-old female, who was living at [facility] over the last 6 months. Apparently, she was on the bathroom commode and she fell and hit her head, and she was discharged back to [the facility]. Apparently, the CT at that time showed no acute findings; however, the patient became more and more lethargic [tired or sluggish] and was unable to hold on a conversation, so she was sent back to the emergency room, at which point, there was an interval development of a | | | |

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| | left-sided subdural hematoma measuring 1.2 centimeters [about 1/2 inch] with a mass effect [a life threatening condition where the hematoma presses against the brain] . . . comfort care measures were initiated given patient's very grave prognosis. Unfortunately, the patient's condition continued to decline and the patient died 9/04/2017."<br><br>Patient 1's Death Certificate, dated 9/14/17, stated her "Immediate Cause of Death" was "Respiratory Failure." The "UNDERLYING CAUSE (diseases or injury that initiated events resulting in death)" were "Acute Subdural Hematoma, Acute Closed Head Trauma."<br><br>During an observation on 9/19/17 at 10:20 AM, the commode chair was noted in a shower room. On the bottom of the chair was a sticker, which stated, "Patient must never be left unattended or unsupervised."<br><br>The facility failed to supervise Patient 1 while she was using the toilet. This a failure resulted in her falling and hitting her head on the floor, causing bleeding inside her skull. Patient 1 died six days later.<br><br>This failure presented imminent danger that death or serious harm would result or substantial probability that death or serious physical harm would result therefrom, and was a direct proximate cause of Patient 1's death. | | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| REDWOOD SPRINGS HEALTHCARE CENTER | 1925 E Houston Ave, Visalia, CA 93292-2345 TULARE COUNTY |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
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