State of California - Health and Human Services Agency — Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 92-1676-0008605-S

Date: 10/06/2011 Time: 2:10 PM

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

Type of Visit : Complaint Investig.
Incident/Complaint No.(s) : CA00266915

Licensee Name: Lake Balboa Health Care , Inc.

Address: 16955 VANOWEN STREET VAN NUYS, CA 91406

License Number: 920000005 Type of Ownership: Profit Corp

Facility Name: LAKE BALBOA CARE CENTER
Address: 16955 VANOWEN ST VAN NUYS, CA 91406
Telephone: (818)343-0700
Facility Type: Skilled Nursing Facility
Facility ID: 920000059

Capacity: 50

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $750.00	DEADLINE FOR COMPLIANCE 10/6/11 5:00 p.m.
72313(a)(2) 72311(a)(2)	**CLASS B CITATION -- PATIENT CARE** Class B Citation—Patient Care Intent 8/9/11 Title 22 Section 72313(a)(2) (a) Medications and treatment shall be administered as follows: (2) Medications and treatment shall be administered as prescribed. Title 22 Section 72311 (a)(2) (a) Nursing services shall include, but not limited to, the following: (2) Implementing of each patient's care plan according to the methods indicated. Each patient's care shall be based on this plan. Based on observation, interview and record review, the facility failed to administer oxygen at a flow rate to maintain a patient's blood oxygen saturation rate above 92 percent as was ordered by the physician and failed to implement a patient's plan of care to ensure oxygen delivery was titrated (adjust the amount of oxygen) to maintain the patient's oxygen saturation above 95 percent during a vasovagal syncope episode as care planned. Patient 1, who was having a vasovagal syncope episode during defecation, and had an oxygen saturation rate of 84 percent with five liters of oxygen through a nasal cannula, was not administered an increased amount of oxygen flow to titrate the oxygen saturation rate to above 92 percent as ordered by the physician and above 95 percent as care planned.		

Name of Evaluator:
Alisa Gorodetskaya
HFEN

Evaluator Signature : Agorodetskaya

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

Signature : Craig Barron
Name : Craig Barron
Title : Administrator

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

State of California - Health and Human Services Agency | Department of Public Health

SECTION 1424 NOTICE | Page 2 of 7

CITATION NUMBER: 92-1676-0008605-S | Date: 10/06/2011 Time: _____

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

Defecation syncope is a temporary loss of consciousness (syncope) upon defecating (having a bowel movement). The situations that trigger this reaction are diverse and include straining while urinating or defecating. Syncope is caused by a reflex of the involuntary nervous system called the vasovagal reaction. The vasovagal reaction leads the heart to slow down (bradycardia), and at the same time it leads the nerves that serve the blood vessels in the legs to permit those vessels to dilate (widen). The result is that the heart puts out less blood, the blood pressure drops, and circulating blood tends to go into the legs rather than to the head. The brain is deprived of oxygen, and the fainting episode occurs (Lipincott, 2010).

On May 5, 2011, at 1 p.m., an unannounced visit was made to the facility to investigate a complaint alleging Patient 1 was not provided an adequate amount of oxygen during an emergency situation when the patient became unresponsive while having a vasovagal syncope episode during defecation.

According to the admission record, Patient 1 had eight re-admissions to the facility since his original admission on November 15, 2003. Patient 1's last re-admission was on September 8, 2009. The patient's admitting diagnoses were as follows:

1. Renal insufficiency.
2. Non-insulin dependent diabetes mellitus.
3. Atrial fibrillation.
4. Parkinson's disease.
5. Orthostatic hypotension.
6. Aortic stenosis.
7. Aortic aneurism.
8. Chronic kidney disease stage IV.
9. Anemia.
10. Hypertension.
11. Hyperlipidemia.
12. Metabolic encephalopathy.
13. Catatonia.
14. Anxiety.
15. Congestive Heart Failure (CHF).
16. Chronic Obstructive Pulmonary Disease (COPD).
17. Vasovagal Defecation Syncope.

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

The Minimum Data Set (MDS) assessment dated January 12, 2011, indicated the patient had severely impaired cognitive skills for daily decision making, was totally dependent on staff for activities of daily living, was always incontinent of bowel and bladder, and had respiratory treatment with oxygen.

Based on a video recording provided by a family member and Patient 1's record, on January 21, 2011, at approximately 6:10 p.m., the patient had a defecation syncope episode.

A review of the patient's clinical record indicated the patient began to have vasovagal episodes precipitated by a bowel movement in November 2009, and he had between 15 to 20 such episodes prior to his last episode on January 21, 2011.

According to the licensed nurse progress notes dated January 21, 2011, at 5:30 p.m., and an interview with the Certified Nursing Assistant (CNA 1) on August 12, 2011, at 2 p.m., CNA 1 was at the patient's bedside feeding him dinner. The patient was in his usual mental state with periods of agitation, mumbling and being noisy. The patient consumed 100 percent of his meal. Based on a family member's video recording and the facility's surveillance video of events taking place in the patient's room, at about 5:50 p.m., CNA 1 left the patient in an erect position (head of bed at 90 degrees), after she finished feeding him, and stepped out of the room. The patient was alert without agitation, spontaneously opening his eyes and verbally responding. CNA 1 stated she was frequently coming back to the patient's room to check on him. At about 6:10 p.m., CNA 1 checked on the patient and found him to be "quiet" and not responding back when she called him by his name. CNA 1 immediately communicated through her two-way radio (walkie-talkie) to the Licensed Vocational Nurse (LVN 1) about the patient's condition.

LVN 1 responded right away and went to the patient's room. According to the interview with LVN 1 on August 9, 2011, at 3 p.m., licensed nurse notes, a family member's video and facility's surveillance video, LVN 1 entered the patient's room at 6:11 p.m. and instructed CNA 1 to call a Registered Nurse (RN). LVN 1 said she brought with her a portable blood pressure monitor and a pulse oxymetry device (for measuring oxygen saturation). LVN 1 stated the resident was sitting up in bed, looked pale but was verbally responsive. There was an oxygen concentrator at the patient's bedside. LVN 1 stated she initially provided the patient with oxygen at two liters per minute (L/min) through a

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

nasal cannula (tubes delivering oxygen directly into the nose), placed the pulse oxymetry device, and then checked his oxygen saturation rate, which was above 90 percent. LVN 1 said she checked the patient's blood pressure and pulse but could not recall the numbers. LVN 1 placed the patient's head of bed down 30 degrees, elevated his legs a "little", and turned him on his left side. LVN 1 stated that the patient's face color improved, he was breathing slowly, and he started to have a bowel movement.

A review of the patient's clinical record indicated there was no documented evidence to reflect LVN 1's above actions in response to CNA 1's call with the report on the patient's change of condition.

According to the licensed nurse progress note dated January 21, 2011, at 6:10 p.m., the patient had an oxygen saturation rate of 84 percent while being administered oxygen at five L/min through a nasal cannula. The patient's blood pressure was 100/60. There was no documentation to reflect the patient's pulse rate.

During an interview with the Registered Nurse (RN 1) on June 6, 2011, at 3:10 p.m, she stated when she walked into the patient's room on January 21, 2011, at approximately 6 p.m., Patient 1 was pale but breathing. RN 1 called him by his name, stimulated him by touching his shoulder, but the patient was not responding. RN 1 said she turned the patient to his left side and checked his oxygen saturation. It was at 84 percent while he was receiving five L/min through a nasal cannula. RN 1 stated the reason she turned the patient on his left side was to facilitate the bowel movement. RN 1 stated while the patient was lying on his left side, she noticed his lips were turning blue. RN 1 instructed LVN 1 to go get a crash cart (a set of trays/drawers/shelves on wheels used in emergency situations for dispensing of emergency medication and/or equipment at the site of the medical emergency to potentially save a life).

During a second interview with RN 1 on August 12, 2011, at 12:30 p.m., she said when she walked into the patient's room on January 21, 2011, at about 6 p.m., he was already on his left side, the head of his bed was down, his legs were elevated, and he was receiving oxygen through a nasal cannula at five L/min. The patient was breathing, had vital signs, and was "mumbling." RN 1 stated his oxygen saturation was at 84 percent, but was increasing to 88 percent and 90 percent, and at one time, it went up to 92 percent. RN 1 said that when she sent LVN 1 out to get the crash cart, the patient was breathing, but was not recovering from an oxygen saturation of 88 percent with the administration of oxygen at five L/min.

State of California - Health and Human Services Agency | Department of Public Health

SECTION 1424 NOTICE | Page 5 of 7

CITATION NUMBER: 92-1676-0008605-S | Date: 10/06/2011 Time: _____

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	There was no documented evidence in the patient's clinical record to support RN 1's statements given on the August 12, 2011, interview, regarding the fluctuation or measurement of Patient 1's oxygen saturation rate. During an interview with LVN 1 on August 9, 2011, at 3 p.m., she stated when she brought the crash cart into the patient's room, nurses connected the patient to the crash cart E-tank (oxygen tank with maximum capacity of 15 L/min) and he was given oxygen at 15 L/min through a nasal cannula. While receiving the oxygen supplement at 15 L/min through a nasal cannula, the patient's oxygen saturation rate was at 88 to 89 percent. Then, the oxygen delivery method was changed to a face mask, and administered at 15 L/min. During an interview with RN 1 on August 12, 2011, at 12:30 p.m., she said after LVN 1 brought the crash cart into the room, she left the patient's room to call 911. RN 1 said when she was leaving the room, the patient had a pulse (she was not able to recall the heart rate), chest movement, and his oxygen saturation rate was at 88 percent on 15 L/min through a facial mask. According to the facility's video surveillance timeline, RN 1 walked into the patient's room on January 21, 2011, at 6:12:38 p.m., and LVN 1 brought the crash cart into the patient's room at 6:17:12 p.m. On June 8, 2011, at 1 p.m., the facility's surveillance video reflecting recorded events taking place in the patient's room on January 21, 2011, was viewed in the presence of the Administrator and the Director of Nursing (DON). According to the video, LVN 1 left Patient 1's room at 6:17:52 p.m., after she brought a crash cart into the room. RN 1 left the room at 6:18:56 p.m., leaving CNA 1 alone with Patient 1, whose condition was requiring emergency interventions. Based on the facility's video, at 6:19:45 p.m., LVN 2 walked into the patient's room. During an interview with LVN 2 on August 9, 2011, at 3:30 p.m., she stated when she walked into the patient's room on January 21, 2011, (could not recall the time) in response to RN 1's request, Patient 1 was lying on his left side, and CAN 1 was at the bed side observing him. LVN 2 stated that her focus was to make sure the patient was breathing. LVN 2 said the patient had a pulse oxymetry device applied, however it was not "properly put on, the tip was not on the patient's finger, and there was no reading." LVN 2 said the patient was receiving oxygen through a facial mask at 15 L/min. After repositioning the pulse oxymeter tip correctly on the patient's finger, the device

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

registered 80 percent oxygen saturation. When RN 1 came back, she said to start cardiopulmonary resuscitation.

Cardiopulmonary resuscitation (CPR) is an emergency procedure which is performed in an effort to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing in a person in cardiac arrest. It is indicated in those who are unresponsive with no breathing or abnormal breathing. CPR involves chest compressions at least 5 cm deep and at a rate of at least 100 per minute in an effort to create artificial circulation by manually pumping blood through the heart. In addition, the rescuer may provide breaths by either exhaling into the subject's mouth or utilizing a device that pushes air into the subject's lungs. CPR's main purpose is to restore partial flow of oxygenated blood to the brain and heart (Lipincott, 2010).

According to the facility's video, CPR was started at 6:22 p.m. and paramedics arrived at 6:24:25 p.m.

A review of Patient 1's clinical record revealed there was a physician's order dated January 17, 2011, when the patient became verbally non-responsive, staff were to keep him on the bed with the head of the bed lowered and lower extremities elevated, until he becomes responsive, and to start oxygen continuously through a nasal cannula to titrate oxygen above 92 percent.
During an interview with the DON on June 6, 2011, at 3 p.m., she said that Patient 1 had many syncope episodes precipitated by a bowel movement. The DON stated that licensed and non-licensed nurses were trained, in-serviced, and were knowledgeable on how to intervene during syncope episodes to prevent the patient from fainting.

There was a plan of care identified and dated December 30, 2010, for the risk of syncope episodes, low heart rate and loss of consciousness during defecation. One of the interventions was to lay the patient down, lower his head, elevate the legs, and provide oxygen as ordered. According to the care plans dated January 6, 2011, and January 16, 2011, for actual syncope episodes, the interventions were as follows: check the patient's vital signs, monitor oxygen saturation "95 percent", place the head of bed flat and elevate the legs.

During an interview with the Administrator, DON, and RN 1, on June 6, 2011, at 3:40 p.m., they confirmed that the oxygen concentrator maximum capacity is five L/min, and for nurses to administer more oxygen supply to the patient, it would require a bigger capacity device such as an E-tank. The E-tank is always located on the crash cart.

State of California - Health and Human Services Agency | Department of Public Health

SECTION 1424 NOTICE | Page 7 of 7

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SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	According to the facility's video and an interview with the Administrator, DON and RN 1, the E-tank was not in use, for Patient 1, from 6:12:38 p.m. to 6:17:12 p.m. The Administrator and DON said that based on their previous experience with Patient 1's syncope episodes, it took three to eight minutes for the patient to recover after the intervention measures and utilizing an oxygen concentrator only. The facility failed to administer oxygen at a flow rate to maintain a patient's blood oxygen saturation rate above 92 percent as was ordered by the physician and failed to implement a patient's plan of care to ensure oxygen delivery was titrated (adjust the amount of oxygen) to maintain the patient's oxygen saturation above 95 percent during a vasovagal syncope episode as care planned. Patient 1, who was having a vasovagal syncope episode during defecation, and had an oxygen saturation rate of 84 percent with five liters of oxygen through a nasal cannula, was not administered an increased amount of oxygen flow to titrate the oxygen saturation rate to above 92 percent as ordered by the physician and above 95 percent as care planned. The above violation had a direct relationship to the health, safety and security 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

POC accepted on 10/6/11 (CG)

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
	056180	A. BUILDING _____ B. WING _____	08/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE BALBOA CARE CENTER	16955 VANOWEN ST, VAN NUYS, CA 91406 LOS ANGELES 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
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit: CLASS B CITATION -- PATIENT CARE 92-1676-0008605-S Complaint(s): CA00266915 Representing the Department of Public Health: Surveyor ID # 17135, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Class B Citation—Patient Care Intent 8/9/11 Title 22 Section 72313(a)(2) (a) Medications and treatment shall be administered as follows: (2) Medications and treatment shall be administered as prescribed. Title 22 Section 72311 (a)(2) (a) Nursing services shall include, but not limited to, the following: (2) Implementing of each patient's care plan according to the methods indicated. Each patient's care shall be based on this plan. Based on observation, interview and record review, the facility failed to administer oxygen at a flow rate to maintain a patient's blood oxygen saturation rate above 92 percent as was ordered by the physician		-The facility will ensure to titrate and administer oxygen at a flow rate to maintain a patient's blood oxygen saturation rate as prescribed/ordered by the physician and ensure implementation of plan of care during vasovagal syncope by a licensed nurse. -An in-service was given on 5/10/11; 6/7/11; 7/12/11; 8/11/11; 9/23/11 by Director of Nurses to licensed nurses regarding change of condition; oxygen usage including titration of oxygen to maintain oxygen saturation as prescribed by physician and during vasovagal syncope. -All new admit residents with orders to titrate oxygen will be monitored by a licensed nurse using pulse oximeter to measure oxygen saturation as prescribed by physician to maintain desired oxygen saturation. -Medical Records will audit all residents admitted to facility with medical diagnosis of vasovagal syncope and results given to DON for follow-up and monitoring for further interventions if indicated. -Results will be submitted to QA Committee for further interventions if indicated. -The DON and Administrator will be responsible for monitoring and implementing this process.	

Event ID: YYZ611 10/5/2011 12:44:54PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Craig Brown Administrator 10/6/11

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.

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
	056180	A. BUILDING _____ B. WING _____	08/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE BALBOA CARE CENTER	16955 VANOWEN ST, VAN NUYS, CA 91406 LOS ANGELES 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
	Continued From page 1 and failed to implement a patient's plan of care to ensure oxygen delivery was titrated (adjust the amount of oxygen) to maintain the patient's oxygen saturation above 95 percent during a vasovagal syncope episode as care planned. Patient 1, who was having a vasovagal syncope episode during defecation, and had an oxygen saturation rate of 84 percent with five liters of oxygen through a nasal cannula, was not administered an increased amount of oxygen flow to titrate the oxygen saturation rate to above 92 percent as ordered by the physician and above 95 percent as care planned. Defecation syncope is a temporary loss of consciousness (syncope) upon defecating (having a bowel movement). The situations that trigger this reaction are diverse and include straining while urinating or defecating. Syncope is caused by a reflex of the involuntary nervous system called the vasovagal reaction. The vasovagal reaction leads the heart to slow down (bradycardia), and at the same time it leads the nerves that serve the blood vessels in the legs to permit those vessels to dilate (widen). The result is that the heart puts out less blood, the blood pressure drops, and circulating blood tends to go into the legs rather than to the head. The brain is deprived of oxygen, and the fainting episode occurs (Lipincott, 2010). On May 5, 2011, at 1 p.m., an unannounced visit was made to the facility to investigate a complaint alleging Patient 1 was not provided an adequate amount of oxygen during an emergency situation		Title 22 Section 72313 (a)(2) Title 22 Section 72311 (a)(2) Submission of this Plan of Correction is not legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interests against the facility, the administrator, or any employees, agents, or other individual who may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or an agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth by the survey agency. The submission of the plan of correction within the time frame should in no way be considered or construed as agreement with the allegations of non-compliance of admissions by the facility. This plan of correction shall constitute this facilities credible allegation of compliance as outlined by Section 1280 of the California Health and Safety Code. Further, the Los Angeles County Elderly Death Review Board reviewed this same complaint and associated evidence in March 2011 and found "the care given was reasonable and appropriate given the setting."	10/6/11

Event ID:YYZ611 10/5/2011 12:44:54PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE BALBOA CARE CENTER	16955 VANOWEN ST, VAN NUYS, CA 91406 LOS ANGELES COUNTY

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	Continued From page 2 when the patient became unresponsive while having a vasovagal syncope episode during defecation. According to the admission record, Patient 1 had eight re-admissions to the facility since his original admission on November 15, 2003. Patient 1's last re-admission was on September 8, 2009. The patient's admitting diagnoses were as follows: 1. Renal insufficiency. 2. Non-insulin dependent diabetes mellitus. 3. Atrial fibrillation. 4. Parkinson's disease. 5. Orthostatic hypotension. 6. Aortic stenosis. 7. Aortic aneurism. 8. Chronic kidney disease stage IV. 9. Anemia. 10. Hypertension. 11. Hyperlipidemia. 12. Metabolic encephalopathy. 13. Catatonia. 14. Anxiety. 15. Congestive Heart Failure (CHF). 16. Chronic Obstructive Pulmonary Disease (COPD). 17. Vasovagal Defecation Syncope. The Minimum Data Set (MDS) assessment dated January 12, 2011, indicated the patient had severely impaired cognitive skills for daily decision making, was totally dependent on staff for activities of daily living, was always incontinent of bowel and bladder, and had respiratory treatment with oxygen.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Continued From page 3 Based on a video recording provided by a family member and Patient 1's record, on January 21, 2011, at approximately 6:10 p.m., the patient had a defecation syncope episode. A review of the patient's clinical record indicated the patient began to have vasovagal episodes precipitated by a bowel movement in November 2009, and he had between 15 to 20 such episodes prior to his last episode on January 21, 2011. According to the licensed nurse progress notes dated January 21, 2011, at 5:30 p.m., and an interview with the Certified Nursing Assistant (CNA 1) on August 12, 2011, at 2 p.m., CNA 1 was at the patient's bedside feeding him dinner. The patient was in his usual mental state with periods of agitation, mumbling and being noisy. The patient consumed 100 percent of his meal. Based on a family member's video recording and the facility's surveillance video of events taking place in the patient's room, at about 5:50 p.m., CNA 1 left the patient in an erect position (head of bed at 90 degrees), after she finished feeding him, and stepped out of the room. The patient was alert without agitation, spontaneously opening his eyes and verbally responding. CNA 1 stated she was frequently coming back to the patient's room to check on him. At about 6:10 p.m., CNA 1 checked on the patient and found him to be "quiet" and not responding back when she called him by his name. CNA 1 immediately communicated through her two-way radio (walkie-talkie) to the Licensed Vocational Nurse (LVN 1) about the patient's			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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
	056180	A. BUILDING _____ B. WING _____	08/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE BALBOA CARE CENTER	16955 VANOWEN ST, VAN NUYS, CA 91406 LOS ANGELES 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
	Continued From page 4 condition. LVN 1 responded right away and went to the patient's room. According to the interview with LVN 1 on August 9, 2011, at 3 p.m., licensed nurse notes, a family member's video and facility's surveillance video, LVN 1 entered the patient's room at 6:11 p.m. and instructed CNA 1 to call a Registered Nurse (RN). LVN 1 said she brought with her a portable blood pressure monitor and a pulse oxymetry device (for measuring oxygen saturation). LVN 1 stated the resident was sitting up in bed, looked pale but was verbally responsive. There was an oxygen concentrator at the patient's bedside. LVN 1 stated she initially provided the patient with oxygen at two liters per minute (L/min) through a nasal cannula (tubes delivering oxygen directly into the nose), placed the pulse oxymetry device, and then checked his oxygen saturation rate, which was above 90 percent. LVN 1 said she checked the patient's blood pressure and pulse but could not recall the numbers. LVN 1 placed the patient's head of bed down 30 degrees, elevated his legs a "little", and turned him on his left side. LVN 1 stated that the patient's face color improved, he was breathing slowly, and he started to have a bowel movement. A review of the patient's clinical record indicated there was no documented evidence to reflect LVN 1's above actions in response to CNA 1's call with the report on the patient's change of condition. According to the licensed nurse progress note dated January 21, 2011, at 6:10 p.m., the patient			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.

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
	056130	A. BUILDING _____ B. WING _____	08/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE BALBOA CARE CENTER	16955 VANOWEN ST, VAN NUYS, CA 91406 LOS ANGELES 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
	Continued From page 5 had an oxygen saturation rate of 84 percent while being administered oxygen at five L/min through a nasal cannula. The patient's blood pressure was 100/60. There was no documentation to reflect the patient's pulse rate. During an interview with the Registered Nurse (RN 1) on June 6, 2011, at 3:10 p.m, she stated when she walked into the patient's room on January 21, 2011, at approximately 6 p.m., Patient 1 was pale but breathing. RN 1 called him by his name, stimulated him by touching his shoulder, but the patient was not responding. RN 1 said she turned the patient to his left side and checked his oxygen saturation. It was at 84 percent while he was receiving five L/min through a nasal cannula. RN 1 stated the reason she turned the patient on his left side was to facilitate the bowel movement. RN 1 stated while the patient was lying on his left side, she noticed his lips were turning blue. RN 1 instructed LVN 1 to go get a crash cart (a set of trays/drawers/shelves on wheels used in emergency situations for dispensing of emergency medication and/or equipment at the site of the medical emergency to potentially save a life). During a second interview with RN 1 on August 12, 2011, at 12:30 p.m., she said when she walked into the patient's room on January 21, 2011, at about 6 p.m., he was already on his left side, the head of his bed was down, his legs were elevated, and he was receiving oxygen through a nasal cannula at five L/min. The patient was breathing, had vital signs, and was "mumbling." RN 1 stated his oxygen saturation was at 84 percent, but was			

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
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	Continued From page 6 increasing to 88 percent and 90 percent, and at one time, it went up to 92 percent. RN 1 said that when she sent LVN 1 out to get the crash cart, the patient was breathing, but was not recovering from an oxygen saturation of 88 percent with the administration of oxygen at five L/min. There was no documented evidence in the patient's clinical record to support RN 1's statements given on the August 12, 2011, interview, regarding the fluctuation or measurement of Patient 1's oxygen saturation rate. During an interview with LVN 1 on August 9, 2011, at 3 p.m., she stated when she brought the crash cart into the patient's room, nurses connected the patient to the crash cart E-tank (oxygen tank with maximum capacity of 15 L/min) and he was given oxygen at 15 L/min through a nasal cannula. While receiving the oxygen supplement at 15 L/min through a nasal cannula, the patient's oxygen saturation rate was at 88 to 89 percent. Then, the oxygen delivery method was changed to a face mask, and administered at 15 L/min. During an interview with RN 1 on August 12, 2011, at 12:30 p.m., she said after LVN 1 brought the crash cart into the room, she left the patient's room to call 911. RN 1 said when she was leaving the room, the patient had a pulse (she was not able to recall the heart rate), chest movement, and his oxygen saturation rate was at 88 percent on 15 L/min through a facial mask. According to the facility's video surveillance timeline, RN 1 walked into the patient's room on			

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	Continued From page 7 January 21, 2011, at 6:12:38 p.m., and LVN 1 brought the crash cart into the patient's room at 6:17:12 p.m. On June 8, 2011, at 1 p.m., the facility's surveillance video reflecting recorded events taking place in the patient's room on January 21, 2011, was viewed in the presence of the Administrator and the Director of Nursing (DON). According to the video, LVN 1 left Patient 1's room at 6:17:52 p.m., after she brought a crash cart into the room. RN 1 left the room at 6:18:56 p.m., leaving CNA 1 alone with Patient 1, whose condition was requiring emergency interventions. Based on the facility's video, at 6:19:45 p.m., LVN 2 walked into the patient's room. During an interview with LVN 2 on August 9, 2011, at 3:30 p.m., she stated when she walked into the patient's room on January 21, 2011, (could not recall the time) in response to RN 1's request, Patient 1 was lying on his left side, and CAN 1 was at the bed side observing him. LVN 2 stated that her focus was to make sure the patient was breathing. LVN 2 said the patient had a pulse oxymetry device applied, however it was not "properly put on, the tip was not on the patient's finger, and there was no reading." LVN 2 said the patient was receiving oxygen through a facial mask at 15 L/min. After repositioning the pulse oxymeter tip correctly on the patient's finger, the device registered 80 percent oxygen saturation. When RN 1 came back, she said to start cardiopulmonary resuscitation.			

Event ID:YYZ611 10/5/2011 12:44:54PM

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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	Continued From page 8 Cardiopulmonary resuscitation (CPR) is an emergency procedure which is performed in an effort to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing in a person in cardiac arrest. It is indicated in those who are unresponsive with no breathing or abnormal breathing. CPR involves chest compressions at least 5 cm deep and at a rate of at least 100 per minute in an effort to create artificial circulation by manually pumping blood through the heart. In addition, the rescuer may provide breaths by either exhaling into the subject's mouth or utilizing a device that pushes air into the subject's lungs. CPR's main purpose is to restore partial flow of oxygenated blood to the brain and heart (Lipincott, 2010). According to the facility's video, CPR was started at 6:22 p.m. and paramedics arrived at 6:24:25 p.m. A review of Patient 1's clinical record revealed there was a physician's order dated January 17, 2011, when the patient became verbally non-responsive, staff were to keep him on the bed with the head of the bed lowered and lower extremities elevated, until he becomes responsive, and to start oxygen continuously through a nasal cannula to titrate oxygen above 92 percent. During an interview with the DON on June 6, 2011, at 3 p.m., she said that Patient 1 had many syncope episodes precipitated by a bowel movement. The DON stated that licensed and			

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	Continued From page 9 non-licensed nurses were trained, in-serviced, and were knowledgeable on how to intervene during syncope episodes to prevent the patient from fainting. There was a plan of care identified and dated December 30, 2010, for the risk of syncope episodes, low heart rate and loss of consciousness during defecation. One of the interventions was to lay the patient down, lower his head, elevate the legs, and provide oxygen as ordered. According to the care plans dated January 6, 2011, and January 16, 2011, for actual syncope episodes, the interventions were as follows: check the patient's vital signs, monitor oxygen saturation "95 percent", place the head of bed flat and elevate the legs. During an interview with the Administrator, DON, and RN 1, on June 6, 2011, at 3:40 p.m., they confirmed that the oxygen concentrator maximum capacity is five L/min, and for nurses to administer more oxygen supply to the patient, it would require a bigger capacity device such as an E-tank. The E-tank is always located on the crash cart. According to the facility's video and an interview with the Administrator, DON and RN 1, the E-tank was not in use, for Patient 1, from 6:12:38 p.m. to 6:17:12 p.m. The Administrator and DON said that based on their previous experience with Patient 1's syncope episodes, it took three to eight minutes for the patient to recover after the intervention measures and utilizing an oxygen concentrator only. The facility failed to administer oxygen at a flow			

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	Continued From page 10 rate to maintain a patient's blood oxygen saturation rate above 92 percent as was ordered by the physician and failed to implement a patient's plan of care to ensure oxygen delivery was titrated (adjust the amount of oxygen) to maintain the patient's oxygen saturation above 95 percent during a vasovagal syncope episode as care planned. Patient 1, who was having a vasovagal syncope episode during defecation, and had an oxygen saturation rate of 84 percent with five liters of oxygen through a nasal cannula, was not administered an increased amount of oxygen flow to titrate the oxygen saturation rate to above 92 percent as ordered by the physician and above 95 percent as care planned. The above violation had a direct relationship to the health, safety and security of Patient 1.			

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