Department of
SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 507004251
Report Date: 10/12/2021
Date Signed: 10/12/2021 09:06:28 AM

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY **FACILITY EVALUATION REPORT**	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 2525 NATOMAS PARK DR. STE.270 SACRAMENTO, CA 95833

FACILITY NAME:	PACIFICA SENIOR LIVING MODESTO			**FACILITY NUMBER:**	507004251
ADMINISTRATOR:	THERESA L PETTAPIECE			**FACILITY TYPE:**	740
ADDRESS:	2325 ST PAUL'S WAY			**TELEPHONE:**	(209) 491-0800
CITY:	MODESTO	**STATE:** CA		**ZIP CODE:**	95355
CAPACITY:	73	**CENSUS:** 59		**DATE:**	10/12/2021
TYPE OF VISIT:	Case Management - Legal/Non-compliance	UNANNOUNCED		**TIME BEGAN:**	08:00 AM
MET WITH:	Rashmika Sharma			**TIME COMPLETED:**	09:15 AM

NARRATIVE

Licensing Program Analyst (LPA) Avelina Martinez arrived at this facility unannounced to conduct a case management visit. This visit is to deliver a civil penalty regarding a substantiated lack of care and supervision allegation. LPA Avelina Martinez met with Rashmika Sharma and explained the purpose of the visit.

On April 14, 2021, the Department concluded a complaint investigation. Which alleged the following: due to insufficient staffing resident sustained a fall and was seriously injured and due to staff neglect, a resident (R1) was able to leave a secured egress door and was later found in the patio.
The licensee was cited for violating California Code of Regulations Title 22, § 87464(f)(1) for failure to provide care and supervision.

The investigation revealed that R1 moved into Pacifica Senior Living Modesto in January of 2020. Since moving into Pacifica Senior Living Modesto, R1 has fallen multiple times with injuries. R1's falls are as follows:

February 3, 2020, R1 was observed on the floor at 4:30 PM, and R1 reported hitting his head and back during the fall. R1 also reported feeling head and back pain. R1 was sent to the emergency room (ER) on this day. The ER conducted imaging test, which included CT Brain WO Contrast, CT Lumbar Spine WO Contrast, and Electrocardiogram. R1 was diagnosed with a lumbosacral strain, and minor fall head injury. Fall prevention instructions were included in the hospital summary report.

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SUPERVISOR'S NAME: Czarrina A Camilon-Lee	**TELEPHONE:** (916) 263-4723
LICENSING EVALUATOR NAME: Avelina Martinez	**TELEPHONE:** (916) 431-8935
LICENSING EVALUATOR SIGNATURE:	**DATE:** 10/12/2021

I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE: **DATE:** 10/12/2021

This report must be available at Child Care and Group Home facilities for public review for 3 years.

FACILITY NAME: PACIFICA SENIOR LIVING MODESTO **FACILITY NUMBER:** 507004251

VISIT DATE: 10/12/2021

NARRATIVE

February 14, 2020, R1 was walking in the hallway prior to falling, R1 fell at approximately 1:00 PM trying to sit on a chair.

July 2, 2020, R1 was sent to the ER at 8:18 PM due to a fall. R1 was diagnosed with blunt head trauma. Hospital discharge instructions included how to avoid another head trauma and how to avoid falls.

October 1, 2020 R1 fell out of bed, and it was reported R1 hit his head. R1 was sent to the ER on this day. Hospital notes recorded time is 6:35 PM. Furthermore, Hospital notes indicated R1 was diagnosed with a left side subdural hematoma. R1 was discharged from the hospital on 10/02/2020

October 2, 2020, at the early morning shift, R1 slipped out of his chair onto the ground, and no injuries were noted. On this same date at 3:30 PM, R1 was observed on the floor besides his bed. Facility documentation reports no injuries.

October 5, 2020, near or around 2:06 PM, R1 was found laying supine on the ground. R1 was diagnosed with mild interval enlargement of the left hemispheric subacute on chronic subdural hematoma.

The facility's 7.69 fall management policy states, " the staff member who responds to the fall is to complete an occurrence first responder work sheet, and the Resident Care Director (RCD) will use the Post-Fall Tracking & Intervention form to analyze each fall and implement new interventions as warranted. This process will be initiated upon the first fall and analyze each subsequent fall as directed on the form. During the investigation and file review Post-Fall Tracking & intervention forms were not found in R1's file. In addition, R1's Needs and Service Plan report did not include a fall prevention plan and stated, "no falls."

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

FACILITY EVALUATION REPORT (Cont)

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION
CCLD Regional Office, 2525 NATOMAS PARK DR. STE.270
SACRAMENTO, CA 95833

FACILITY NAME: PACIFICA SENIOR LIVING MODESTO **FACILITY NUMBER:** 507004251

NARRATIVE

Facility narrative charting notes dated February 3, 2020 states, “PCA was doing rounds to get all of the residents up for dinner…notices resident on the floor…immediately called for med-tech and the nurse… we did a full body exam no visible injury at the time…resident claimed R1 hit R1’s head…R1 was complaining of head pain.” February 3, 2020 medical notes states, “Fall, initial encounter…minor head injury, initial encounter…lumbosacral strain.” Medical health notes included fall prevention information. On July 2, 2020, R1 was sent to an Emergency Department. The Emergency Department summary states, “reason for visit fall…diagnosis…blunt head trauma.” Summary notes included head injury instructions, which included work on your balance and strength. This can help you avoid falls. According to the Mayo Clinic, “A head injury is the most common cause of bleeding within the skull. A head injury may result from motor vehicle or bicycle accidents, falls, assaults, and sports injuries.”

On October 1, 2020, R1 was sent to a Medical Center in Modesto due to falling next to R1’s bed, and R1 was diagnosed with a chronic subdural hematoma. After returning from the hospital, R1 fell two times on October 2, 2020. R1 slipped out of a chair and fell to the ground, and at 3:30 p.m. R1 was observed on the floor next to R1’s bed.

R1’s last reported fall was on October 5, 2020. R1 was found by a maintenance staff. R1 was found lying supine on the ground. On October 5, 2020, R1 was hospitalized and admitted into the intensive care unit (ICU) for two days, and R1 was later transferred to a step-down care unit. During the time R1 was hospitalized, R1 was diagnosed with a mild interval enlargement of the left hemispheric subacute on chronic subdural hematoma. On a October 12, 2020 discharge note, it was noted R1 needed max assistance with feeding and mobilization and home health care was required.

R1’s most egregious fall was on October 5, 2020. It was noted care staff were unaware that R1 was outside; in addition to, not knowing how long R1 was outside. Medical Center notes report fall with unknown downtime. The ambulance record report states, “it was unknown how long R1 was outside at the patio area.” The ambulance report also, indicated staff reported there is no one that does rounds to check the outside. Moreover, during interviews it was stated, “the residents can open the doors despite the door alarms, and they go outside by themselves… sometimes the caregivers are unaware residents are outside.” It was also reported due to being short staffed, residents are left unsupervised on a daily basis, and the facility is unsafe for residents.

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NARRATIVE

Based on file reviews, interviews, and observations, the facility did not follow internal policy 7.69 fall management and did not implement a fall prevention plan for R1. Three hospitalization reports reported the various information: R1 was a fall risk, fall prevention instructions, and head injury instructions. However, R1’s Needs and Service Plan report did not include a fall prevention plan and stated no falls. The facility’s charting notes reported R1 sustained multiple falls with injuries. Some of the injuries sustained are as follows: subdural hematoma, discoloration to lower and upper right arm, contusion to upper right forehead, contusion to left shoulder, brain bleed, blunt head trauma, lumbosacral strain. In addition, R1’s falls required multiple hospital emergency department visits, and a stay in the hospital’s

intensive care unit, home health care, and max assistance with feeding and mobilization. R1's injuries required hospitalization, and R1's injuries resulted in serious bodily injuries.

At the time of the complaint visit on April 21, 2021, the licensee was informed that a civil penalty was still being determined and might be assessed based on Health and Safety Code § 1569.49.

The Department has concluded an analysis and has determined that a civil penalty is warranted for serious bodily injury. Per Welfare and Institutions Code § 15610.67 defines serious bodily injury as "an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of a function of a bodily member, organ, or of mental faculty, or requiring medical intervention, including but not limited to, hospitalization, surgery, or physical rehabilitation."

Today, October 12, 2021, the Department will be issuing a civil penalty per Health and Safety Code § 1569.49 for a violation that the Department constitutes as serious bodily injury in the amount of $10.000. A copy of the LIC 421D was given to Rashmika Sharma and originals were signed. An exit interview was conducted, and copy of this report was issued and provided to Rashmika Sharma. A copy of the Appeal Rights was also provided to Rashmika Sharma. Signature on this report acknowledges receipt of these rights, found on page 2 of LIC 421D.

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