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Department of

SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 342700077
Report Date: 12/30/2020
Date Signed: 12/30/2020 01:27:51 PM

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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:	COURTE AT CITRUS HEIGHTS, THE		FACILITY NUMBER:	342700077
ADMINISTRATOR:	DAVIS, KAYLA		FACILITY TYPE:	740
ADDRESS:	6825 SUNRISE BLVD		TELEPHONE:	(916) 721-0644
CITY:	CITRUS HEIGHTS	STATE: CA	ZIP CODE:	95610
CAPACITY: 48		CENSUS: 33	DATE:	12/30/2020
TYPE OF VISIT:	Case Management - Legal/Non-compliance	UNANNOUNCED	TIME BEGAN:	01:00 PM
MET WITH:	Kayla Davis, Administrator		TIME COMPLETED:	01:30 PM

NARRATIVE

On 12/30/20 Licensing Program Analyst (LPA) Bethany Huusfeldt, spoke with Administrator, Kayla Davis, of The Courte at Citrus Heights to follow up on a substantiated allegation of inadequate supervision that led to an injury. Due to COVID-19 precautions, LPA was unable to meet in person with administrator.

On September 26, 2018 the Department concluded a complaint investigation which alleged inadequate supervision which led to an injury of Resident 1 (R1). The complaint alleged R1 was thrown to the ground by a Resident 2 (R2). R1 was sent to the hospital with injuries.

The allegations were substantiated and the licensee was cited for violating California Code of Regulations (CCR) Title 22, § 87466 – Observation of the Resident for not properly observing R1, documenting behavioral changes of R1, notifying R1's physician in a timely manner, making changes to R1's care plan to adequately address the changes and providing appropriate training to staff in order to meet the resident's needs to ensure the health and safety of residents and staff of the facility.

Resident R2 was admitted to the facility December 17, 2016. Based on records reviewed, R2 was prescribed medication of agitation on May 23, 2018, June 6, 2018, and June 18, 2018.

Continuation on 809-C.

NAME OF LICENSING PROGRAM MANAGER: Troy Ordonez
NAME OF LICENSING PROGRAM ANALYST: Bethany Huusfeldt

LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 12/30/2020

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

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 12/30/2020

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

FACILITY NAME: COURTE AT CITRUS HEIGHTS, THE **FACILITY NUMBER:** 342700077

VISIT DATE: 12/30/2020

NARRATIVE

Staff interviews indicated R2 would become aggressive with staff and would not allow staff to assist R2 after toileting accidents, showering, or administering medications. Interviews were conducted with 14 staff members. Eight (8) of 14 staff stated they observed aggression or agitation from R2. Five (5) staff stated that a few months prior to this incident with R1, R2 was aggressive to other clients at the facility. R2 would sometimes try to hurt other residents. Staff tried to redirect R2 and keep R2 away from other residents. One (1) staff stated they were hit by R2 for trying to protect another resident during a behavioral episode. Staff interviews revealed facility management was aware that R2 was gradually becoming more aggressive. Furthermore, staff interviews indicated staff were reporting behavioral issues with R2 to the assigned nurse and facility management. In addition, interviews showed training for R2's behaviors were not put in place for staff.

On June 12, 2018, R2 was walking down the hallway in the facility when R2 walked up to R1. R2 made a derogatory comment towards R1 and then approached R1 and forcefully pushed R1 to the ground causing R1 to hit her head on the ground. R1 sustained a head injury. R1 was sent to the hospital for evaluation. R1 was diagnosed with a brain bleed (subdural hematoma) and was admitted to the hospital for treatment. According the Cleveland clinic, A subdural hematoma is a type of bleed inside your head. More precisely, it is a type of bleed that occurs within the skull of head but *outside* the actual brain tissue. R1 continued to decline and was placed on hospice care. R1 passed away on June 27, 2018.

There were two (2) witnesses that observed the incident that occurred when R2 pushed R1. Statements made by witnesses indicated R1 was "forcefully" pushed by R2.

The Department reviewed Sacramento County Corner report dated 02/11/2020 which indicated R1's cause of death was due to Craniocerebral Blunt Force Trauma and lists manner of death as Homicide.

Continuation on 809-C.

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NARRATIVE

Based on interviews and record reviews, the licensee failed to properly observe and document R2's behavioral changes. In addition, the facility failed to notify R2's physician of R2 increased agitation and behavioral changes. The facility failed to update R2's needs and service plan to adequately address the changes and provide appropriate training to staff in order to meet R2's needs and ensure the health and safety of all residents and staff of the facility.

R2 had a history of aggressive behaviors of which the facility was aware and yet failed to implement precautions to protect the other residents, the failure to properly supervise R2 constituted a failure to provide adequate supervision and protection to other residents, resulting in the incident which caused R1's death.

At the time of the complaint visit on September 26, 2018, an immediate civil penalty of $500 was issued and the licensee was informed that an additional civil penalty is 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 civil penalty is warranted for a violation determined to have resulted in death of a resident.

Today, 12/30/2020, the Department is issuing a civil penalty per Health and Safety Code § 1569.49 for $15,000 for a determined to have resulted in death of a resident. However, since an immediate civil penalty of $500 was issued on September 26, 2018, the amount of the civil penalty issued today is reduced to $14,500. A copy of the LIC 421D was given to Kayla Davis and originals were signed on file.

Exit interview conducted. A copy of the report issued. Appeal Rights provided. Kayla Davis's signature on this report acknowledges receipt of the Appeal Rights, found on page two of LIC 421D.

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