

California Department of Public Health

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

050578

(X2) MULTIPLE CONSTRUCTION

A BUILDING
B WING

(X3) DATE SURVEY
COMPLETED

C
05/18/2007

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARTIN LUTHER KING, JR - HARBOR HOSPIT

12021 S WILMINGTON AVE
LOS ANGELES, CA 90059

(X4) 10
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH
DEFICENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

10
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION (EACH
CORRECTIVE ACTION SHOULD BE CROSS-
REFERENCED TO THE APPROPRIATE
DEFICENCY)

(X5)
COMPLETE
DATE

A 0001 Initial Comment

A
000

The following reflects the findings of the
Department of Health Services during an
investigation of COMPLAINT #CA00114549.

Representing the Department of Health Services:



A 0121 1280.1(a) HSC Section 1280

A
012

If a licensee of a health facility licensed under
subdivision (a), (b), or (f) of Section 1250
receives a notice of deficiency constituting an
immediate jeopardy to the health or safety of a
patient and is required to submit a plan of
correction, the department may assess the
licensee an administrative penalty in an amount
not to exceed twenty-five thousand dollars
(\$25,000) per violation.

A 0141 1280.1(c) HSC Section 1280

A014

For purposes of this section "immediate jeopardy"
means a situation in which the licensee's
noncompliance with one or more requirements of
licensure has caused, or is likely to cause, serious
injury or death to the patient.

DEFICIENCY CONSTITUTING IMMEDIATE
JEOPARDY,

Licensing and Certification Division

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

7NNQ11

If continuation sheet 1 of 1

California Department of Public Health

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

050578

(X2) MULTIPLE CONSTRUCTION A.

BUILDING

B.W NG

(X3) DATE SURVEY
COMPLETED

C

05/18/2007

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARTIN LUTHER KING, JR - HARBOR HOSPITAL

12021 S WILMINGTON AVE
LOS ANGELES, CA 90059

(X4) D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
-------------------------	--	---------------------	---	--------------------------

E 2701 T22 DIV5 CH1 ART3-70213(c) Nursing Service I E 270
Policies and Procedures.

(C) Policies and procedures which contain competency standards for staff performance in the delivery of patient care shall be established, implemented, and updated as needed for each nursing unit, including standards for the application of restraints. Standards shall include the elements of competency validation for patient care personnel other than registered nurses as set forth in Section 70016, and the elements of competency validation for registered nurses as set forth in Section 70016.1. At least annually, patient care personnel shall receive a written performance evaluation. The evaluation shall include, but is not limited to, measuring individual performance against established competency standards.

This Statute is not met as evidenced by:

E 2941 T22 DIV5 CH1 ART3-70215(b) Planning and Implementing Patient Care I E 294

(b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission.

This Statute is not met as evidenced by:

E18991 T22 DIV5 CH1 ART7-70701(a)(4) Governing Body E1899

Licensing and Certification Division

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6699

7NNQ11

If continuation sheet 1 of 5

California Department of Public Health

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

050578

(X2) MULTIPLE CONSTRUCTION

A BUILDING
B WING

(X3) DATE SURVEY
COMPLETED

C
051181200
7

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARTIN LUTHER KING, JR - HARBOR HOSPIT

12021 S WILMINGTON AVE
LOS ANGELES, CA 90059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------------	--	---------------------	---	--------------------------

E18991 Continued From page 1

E1899

- (a) The governing body shall:
(4) Provide appropriate physical resources and personnel required to meet the needs of the patients and shall participate in planning to meet the health needs of the community.

This Statute is not met as evidenced by:
The above Regulation was NOT MET as evidenced by:

Based on administrative staff interview, medical record and hospital document and personnel file review, the hospital failed to ensure Patient #1 received prompt nursing assessments and medical care when she came to the emergency room for evaluation of an emergency medical problem. The governing body failed to ensure competent and appropriate nurse staffing resources to ensure Patient #1 received prompt care.

A hospital surveillance tape and incident report reviewed on 5118107 showed Patient #1 originally presented to the staff at the ER triage window with pain in her stomach at 0101 hours on 5/9107. The incident report documented that the nurse told the police officers accompanying the patient, "Thanks a lot officers, she's a regular here, this is her third time here. She has already been seen and was discharged." The officers informed the nurse that Patient #1 was complaining of stomach pains. The nurse then told Patient #1 "You have already been seen and there is nothing we can do. You already have an appointment." At 0105 hours Patient #1 slid off of the wheelchair and on to the floor on her knees in a fetal position screaming in pain. The nurse told Patient #1: "Get off the floor and on to a chair."

California Department of Public Health

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

050578

(X2) MULTIPLE CONSTRUCTION A.

BUILDING

B.WING

(X3) DATE SURVEY
COMPLETED

C

05/18/2007

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARTIN LUTHER KING, JR - HARBOR HOSPIT

12021 S WILMINGTON AVE
LOS ANGELES, CA 90059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------------	--	---------------------	---	--------------------------

E18991 Continued From page 2

I E1899

The patient's medical record failed to include documentation of a nursing assessment of Patient #1 at that time. There was no triage category assigned to the patient and she did not receive a medical screening exam to determine if she had an emergency medical condition.

The surveillance tape shows that for approximately 30 minutes staff members walked past the patient or worked to clean the floor next to her without interacting with her. One staff person was observed sitting behind the financial/registration window and had a view of the patient in the lobby. At 0130 hours Patient #1 was on the floor in the ER lobby kicking with her feet. Two staff members looked at the patient and then walked back through the door to an area within the ER. There was no nursing or medical assessment of Patient #1. A male arrived at 0138 hours, checked with Patient #1 and went to the triage window and then out the side door from the ER lobby. The incident report documents the male was a friend of Patient #1. He requested help from the ER triage nurse. The nurse did not conduct an assessment of the patient. He then went to the police window next to the ER and asked them to help the patient because the ER staff would not. The report also documents that the friend called 911 for help but they would not respond because the patient was already at the hospital. During the time she spent in the ER lobby, Patient #1 was not triaged for her priority to be seen in the treatment area, was not provided a medical screening exam, and her presence was not logged into the ER log or her medical record.

The surveillance tape documents that at 0150 hours, police officers arrived and wheeled Patient #1 out of the ER lobby. At 0157 hours Patient #1

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050578	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 05/18/2007
---	---	--	--

NAME OF PROVIDER OR SUPPLIER MARTIN LUTHER KING, JR - HARBOR HOSPIT	STREET ADDRESS, CITY, STATE, ZIP CODE 12021 S WILMINGTON AVE LOS ANGELES, CA 90059
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST BE PRECEDED 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) COMPLET E DATE
--------------------------	---	---------------------	---	---------------------------

E18991 Continued From page 3

I E1899

was wheeled in the chair back in the direction of the side door to the ER lobby. The medical record for Patient #1 contained an Emergency Nursing Flow Sheet for 0200 hours on 5/9/07 when she presented to the ER in full cardiac and respiratory arrest. Attempts by ER staff to resuscitate her were unsuccessful.

The hospital's triage P&P identified that two triage nurses were to be assigned in the ER. The patient's initial contact in the ER would be with a registered nurse. The nurse was to document the patient's name, age and chief complaint during a " cursory assessment" of the patient prior to proceeding to the second nurse who would do the triage. On 5/14/07, the Clinical Nursing Director II stated the first nurse to see the patient documents on the Emergency Nursing Flow Sheet the date and time of arrival, age and sex of the patient, where the patient came in from, how they arrived, who accompanied them and who gave the information for the patient. The Clinical Nursing Director II stated Patient #1 was in the emergency room in the early morning hours of 5/9/07. The nurse at the ER window "eyeballed" the patient. The patient's medical record failed to contain documentation of the nurse's "eyeball" assessment of the patient, or the date and time of her presentation to the ER. A review of nurse staffing showed the ER did not have two nurses assigned to triage patients during the early morning hours of 5/9/07. In addition, the staffing sheets show that 13.58 licensed nurses were needed to care for the 39 patients already receiving treatment in the ER. There were only 11 nurses working, including the triage nurse. The personnel file for the triage nurse showed the last assessment of competence to provide care in the emergency room was in July 2005. A written warning was issued in January 2006 for failure to

California Department of Public Health

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

050578

(X2) MULTIPLE CONSTRUCTION A.

BUILDING
B.WING

(X3) DATE SURVEY
COMPLETED

C
05/18/2007

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MARTIN LUTHER KING, JR - HARBOR HOSPIT

**12021 S WILMINGTON AVE
LOS ANGELES, CA 90059**

(X4) D
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH
DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

D
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION (EACH
CORRECTIVE ACTION SHOULD BE CROSS-
REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5)
COMPLETE
DATE

E18991 Continued From page 4

E1899

follow protocols for patient care. There was no
plan specified for monitoring the employee's
continued performance.

The violation(s) has caused or is likely to cause,
serious injury or death to the patient(s).