POC accepted N. Williams RN 6/27/11

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California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000915	A. BUILDING _____ B. WING _____	C 09/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROTMAN MEDICAL CENTER	3828 DELMAS TERRACE CULVER CITY, CA 90231

(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
E 000	Initial Comments The following reflects the findings of the Department of Public Health during an Entity Reported Incident/Complaint investigation. Complaint Intake Number: CA00231733 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: [redacted], RN, HFEN 1280.1(c) Health and Safety Code Section 1280 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 likely to cause, serious injury or death to the patient. E 294 T22 DIV5 CH1 ART3-70213(a) Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. This Statute is not met as evidenced by: E 294 T22 DIV5 CH1 ART3-70218(b) Planning and Implementing Patient Care (b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning,	E 294	Corrective Action: 1. The Acute Rehab Unit nursing staff will be re-in serviced on the hospital's policies titled (1) **Interdisciplinary Patient Assessment and Care Planning**, and (2) **Documentation: Interdisciplinary Plan of Care** with a focus on the expectation for developing individualized care plans that are appropriate for the patient's strengths and limitations and is based upon the patients assessed needs, goals, and desired outcomes. The in-service will also focus on the requirement to review and revise the Interdisciplinary Plan of Care as the patient's condition warrants, and PRN to reflect changes in condition, to evaluate the patient's response to the care plan and to monitor the effectiveness of the care plan in meeting the patient's needs and progress towards established goals and outcomes. 2. The Acute Rehab Unit nursing staff will be re-in serviced on the hospital's policies titled (1) **Interpreters and Accommodations for Barriers to Communicate**, and (2) **Admission Assessment/Interdisciplinary Plan of Care (Patient Family Education Section)**. The staff will also be re-in serviced on the expectation for documenting complete, clear, concise educational interventions to include patient learning preferences, teaching methods used, readiness/motivation to learn, and the patient's response to teaching.	

Licensing and Certification Division

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

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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:
The Department received a complaint indicating Patient 1 was left unsupervised, fell on the floor and later died.

An unannounced investigation was conducted on September 15, 2010.

Based on interviews and record reviews, the facility failed to assess, implement and update interventions of the nursing plan and develop a specific plan of care for fall prevention for Patient 1 and failed to follow its policy and procedure on falls prevention, which resulted in the patient falling, developing a subdural hematoma (a mass of clotted blood in the brain). Subsequently, the patient was transferred to an intensive care unit (ICU) and later expired after being diagnosed brain dead (irreversible brain damage and loss of brain function, as evidenced by cessation of breathing and other vital reflexes, unresponsiveness to stimuli, absence of muscle activity, and a flat electroencephalogram for a specific length of time).

A review of the facility's investigation report dated April 20, 2009, indicated on [redacted] 2009 at 1:10 p.m., "Staff heard a big bang." The report indicated a therapist found Patient 1 face down on the floor with a right-sided facial abrasion. Urine and feces (stool) were noted in the patient's wheelchair. According to the investigation report, the patient stated he was trying to use the bedside commode and fell. As a result of the fall, Patient 1 developed a post-fall massive intracranial bleed (within the skull) and became

3. The Acute Rehab Unit nursing staff will be re-in serviced on the hospital's policies titled Falls Prevention Program policy with a focus on the expectation for documenting the placement of the yellow arm band on those patients who have been identified as high risk for falls and developing individualized care plans that are appropriate for the patient's strengths and limitations and is based upon the patient's assessed needs, goals, and desired outcomes.

4. The hospital's Falls Prevention Program policy will be revised to reflect the use of non-skid footwear, bed alarms, and chair alarms as general strategies that may be implemented to prevent patients from falling. The hospital will also implement patient education plans to include educational material to be used to educate patients and/or family members about anti-coagulants and safety precautions to take while on the medication and education about fall prevention strategies while in the hospital.

Date of Implementation:

June 17, 2011 and ongoing

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E 294	Continued From page 2 unresponsive. The report concluded the patient's prognosis was extremely poor. On September 16, 2010, a review of Patient 1's medical record and face sheet indicated the patient was an 82 year-old male admitted to the facility on [redacted] 2009. The patient had a diagnosis of acute left cerebral vascular accident (stroke, damage to brain caused by disruption of blood supply) with right-sided weakness. A review of the initial assessment dated [redacted] 2009, indicated the patient was non English speaking and had a history of falls within the last 12 months. The patient had an impaired gait and used an ambulatory (walking) aid. According to the assessment, Patient 1 had a high risk for falls. The initial assessment also indicated the patient had a newly identified weakness with difficulties in performing activities of daily living (ADL) with visional limitations. A review of the Rehabilitation Inpatient Assessment Instrument for Patient 1, dated [redacted] 6, 2009, under the Functional Independence Measure (FIM), indicated the patient required moderate assistance (50% or more) and required auditory and visual assistance in both expression and comprehension of communication. The FIM also indicated Patient 1 was modified dependent requiring 100% supervision in social cognition and memory. A review of a care plan dated April 3, 2009, indicated Patient 1 had impaired physical mobility related to an unsteady gait and weakness. The care plan indicated the staff's interventions included transfer and gait training, and to encourage, supervise, and assist the patient with his activities of daily living (ADL's). Another care	E294	Monitoring Process: The Nursing Director and/or designee will conduct monitoring activity to include monthly audits of a minimum of 10 random medical records of patients assessed to be at high risk of falls and admitted to the Acute Rehab Unit. The monitoring process will consist of review for compliance with developing/documenting individualized care plans that are appropriate for the patient's strengths and limitations and ensuring that it is based upon the patients assessed needs, goals, and desired outcomes. The review will also consist of an audit of the education record to ensure that the documentation is complete, clear, and concise and contains educational interventions to include patient learning preferences, teaching methods used, readiness/motivation to learn, and the patient's response to teaching. This monitoring activity will commence for a period not to exceed 3 months to ensure that compliance is achieved and consistently maintained. Results of the audits will be reported to the hospital's Quality Council. Person(s) Responsible: Nursing Director, Acute Rehab Unit Director, Rehab Services Director of Education	

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plan, dated the same day (April 3, 2009), indicated the patient had a knowledge deficit related to fall prevention. The intervention was not clear or distinct and indicated to initiate the interdisciplinary patient education record. However, it did not indicate what the Interdisciplinary Patient Education Record entailed.

The care plan did not indicate that any educational interventions were implemented such as, brochures or pictures used as reminders, for the patient to use the call bell, use of a sitter, and with consideration of the patient's language deficit in determining interventions to prevent falls, as indicated in their policy.

Another care plan dated April 4, 2009, indicated the patient was at risk for injury related to a fall risk. The interventions for fall prevention included general strategies, reduction strategies and environmental strategies. However, these strategies were not clear or distinct and did not indicate what these strategies were and what specific actions the facility's staff was to incorporate into the patient's care to prevent falls. The plan of care also did not indicate if a yellow armband was placed on the patient to serve as an identifier to staff for falls preventative measures as indicated in their policy titled Falls Prevention Program.

On September 15, 2010, a review of the facility's policy titled, Falls Prevention Program, dated March 2005 and revised March 2007, indicated, under Section D, Fall Prevention Interventions, at risk patients would have a yellow armband placed on the patient's wrist to serve as an identifier for preventative measures for the entire health team. The policy also indicated the patient and family

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would be educated and educational interventions may be used, as well as considering the use of a sitter to engage the patient and remind the patient to ask for assistance if needed.

A review of the Interdisciplinary Patient Education Record dated from April 4-17, 2009, indicated the fall prevention specific content was taught to the patient once during that time, which was on A[redacted], six days after the patient was admitted.

The Patient Education Record indicated the teaching method used for the patient was verbal instructions. There was no indication audio or visual teaching methods were used with Patient 1, per the Rehabilitation Assessment Instrument or the FIM, as previously determined.

The Interdisciplinary Patient Education Record indicated there were factors that influence patient's ability, barriers and readiness to learn (such as cultural beliefs, cognitive limitations, language and communication) and the patient learning preferences (reading, listening, pictures). However, these were not implemented and documented for Patient 1 until [redacted], 2009, after the patient fell and sustained injuries.

During an interview, on September 15, 2010 at 1:55 p.m., the acting director of nursing (DON) stated after reviewing Patient 1's Interdisciplinary Patient Education Record, the factors that influence the patient's learning and preferences (on Page 1) had not been completed.

On September 17, 2010 at 10:20 a.m., during an interview, the nursing director of rehabilitation stated, after reviewing Patient 1's Education Record, fall prevention was documented as being taught only once, which was on [redacted] 2009. A

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E 294	Continued From page 5 further review of the patient's Education Record with the director of rehabilitation revealed there were various days Patient 1's response to teaching was documented by staff as needing further instructions. When the nursing director of rehabilitation was asked about this issue, he stated the patient required continued education, maybe another kind of teaching, maybe visual or demonstration. A review of the "Nursing Flow Sheet/Q Shift charting, dated from April 7- 13, 2009, indicated Patient 1 did not require any ambulatory aid, but the patient's gait (manner of walking) was documented as weak. The patient's fall risk screening score was 45. According to the Morse Fall Risk Screening section of the nursing flow sheet, a score of 45 or higher indicated the patient had a high risk for falls. A review of the nursing charting from April 14-17, 2009, indicated Patient 1 now required ambulatory aid and the patient's gait was impaired. This resulted in the patient's fall risk score increasing to a score of 80. However, these changes were not documented on the patient's care plan with a revision for a plan of care to prevent Patient 1 from falling. A review of the physician's orders dated [redacted] 2009 indicated Patient 1 was to receive one dose of Coumadin 4mg by mouth. The physician's order dated [redacted], 2009 indicated Patient 1 was to receive one dose of Coumadin 6mg by mouth and another dose of 6mg on [redacted] 2009. According to online.lexi.com, Coumadin is an anticoagulent (prevents clotting of blood) associated with increased bleeding risk and has a black box warning (the drug carries a significant	E 294		

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risk of serious or life-threatening adverse effects). Online.lexi.com indicated to use caution with history of falls or significant fall risk and to teach patient safety precautions due to tendency to bleed easily when taking this drug. Also geriatric and cognitive status should be considered, as a risk of bleeding complications has been associated with increased age.

On September 17, 2010, further review of Patient 1's medical record indicated there was no care plan for the use of Coumadin. This indicated the facility did not provide a comprehensive assessment of Patient 1's needs in order to develop and implement an appropriate plan of care.

A review of Patient 1's physician's orders dated [redacted], 2009 at 1:30 p.m., indicated a "STAT" (immediately) computerized tomography (CT) scan of the head, status-post fall to rule out an intracranial bleed, a 1:1 sitter and to hold all therapy. The physician's orders dated the same day at 4:20 p.m., also included a STAT dose of vitamin K 10mg intravenous (within a vein) push (promotes blood clotting), four units fresh frozen plasma (used for blood coagulation deficiency) to be given "STAT" and transfer the patient to ICU.

Review of the physician's orders on [redacted], 2009 at 9:03 a.m., indicated the patient to receive Atropine 1 milligram (mg) intravenous push (helps to increase heart rate and cardiac output), Epinephrine 1 mg intravenous push (helps to restore cardiac rhythm) and a STAT electrocardiogram (traces the electric current of the heart beat).

A review of the nurse's note dated April 19, 2009 at 6:40 p.m., indicated the physician stated

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Patient 1 was clinically brain dead and that the physician would call to inform the family.

A review of the physician's consult dated April 19, 2009 at 6:58 p.m., under the patient's history and physical, indicated Patient 1 was progressing well in rehabilitation up until "today." The consultation indicated the patient had a fall earlier and the CT scan showed a significant acute left-sided subdural hematoma. A repeat CT scan of the head after the patient was transferred to ICU indicated a significant large, left temporoparietal intra-parenchymal (a functional tissue of a morbid growth near the temples) hemorrhage and worsening of the subdural hematoma, as a result the patient's mental status declined. According to the consult, Patient 1 was unresponsive and the hemorrhage had produced severe destruction of crucial parts of the patient's brain. The physician recommended supportive care only (sympathy / encouragement).

A review of the facility's policy and procedure titled Falls Prevention Program dated March 2007, indicated each patient would be reassessed for fall risk every shift, with a change in status, and transferred to another unit as the patient's condition warrants. The policy and procedure indicated this would be documented on the fall scale risk screening area of the nursing flow sheet, and the interdisciplinary plan of care would be updated and modified as needed, at a minimum of every seven days, which was not done for Patient 1. The policy and procedure further indicated the interventions would be planned, implemented and documented on the interdisciplinary plan of care.

These deficiencies, jointly, separately or in any combination, have caused or are likely to cause

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E 294	Continued From page 8 serious injury or death to a patient, and therefore constitute an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1.	E 294		