

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA240000040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/03/2008
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I OF PROVIDER OR SUPPLIER KINDRED HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 550 NORTH MONTEREY ONTARIO, CA 91764
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E 000	<p>Initial Comments</p> <p>The following reflect the findings of the California Department of Public Health during the investigation of an entity reported incident.</p> <p>Entity reported incident: CA00147759</p> <p>Representing the Department of Public Health: [REDACTED] HFEN</p> <p>The inspection was limited to specific entity reported incident investigated and doe not represent the findings of a full inspection of the facility.</p> <p>One deficiency was written as a result of entity reported incident CA00147759</p>	E 000		
.899	<p>T22 DIV5 CH1 ART7-70701(a)(4) Governing Body</p> <p>(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.</p> <p>This Statute is not met as evidenced by: Based on record review and interview the governing body failed to provide appropriate personnel required to meet the needs of this patient. The physician determined the patient needed 1:1 care and the facility failed to provide the resources by failing to follow a physician ' s order for a patient (Patient 1). The facility did not provide a 1 to 1 sitter (one staff member assigned to monitor one patient) for the patient which resulted in Patient 1 pulling out his tracheostomy tube (a hollow tube that is inserted</p>	E1899	<p>Tag # E1899</p> <p><u>Immediate Corrective Action:</u> Kindred Hospital Ontario (KHO) immediately reviewed all active physician orders for sitters currently in house. Nursing Administration ensured appropriate staffing to safely meet the needs of all patients with a physician order for a sitter.</p> <p><u>Systematic Changes to Prevent Recurrence:</u> KHO's policy on Patient Sitters was revised to provide clear delineation of responsibilities. All nursing staff received education regarding the roles and responsibilities of patient sitters. Signatures were obtained on Compliance and Attestation Statements from the staff member each time they were assigned to sit. The Nursing Supervisor (NS) assigns</p>	10/08

Licensing and Certification Division	[REDACTED]	TITLE	[REDACTED] (X6) DATE
LABORATORY DIRECTOR'S OR	[REDACTED] REPRESENTATIVE'S SIGNATURE	[REDACTED]	[REDACTED]

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E1899	<p>Continued From page 1</p> <p>through a patient's neck and into the trachea to enable the patient to breathe), and suffering a cardiac and respiratory arrest, and subsequently expiring.</p> <p>Findings: On 5/6/08, an unannounced visit was made to the facility to investigate a self-reported adverse event.</p> <p>Medical record review revealed that Patient 1 was 53 years old and admitted to the facility with diagnoses including: acute respiratory failure with tracheostomy, history of stroke and traumatic brain injury, tracheal stenosis (narrowing). A review of the nursing care plans for this patient revealed that on 1/9/08, a care plan for "Potential for Injury" was written, with "Decannulation Precautions" (precautions to prevent the removal of the tracheostomy tube) listed as an intervention to be implemented. Further record review revealed a physician's order, dated 1/9/08, for the use of mittens (bulky padded type gloves) and soft wrist restraints due to the patient's attempts to remove medical devices including "Trach [tracheostomy] tube, IV (intravenous lines) and feeding tube", which could cause a life-threatening situation or interference with treatment plans.</p> <p>Review of the physician's orders revealed that on 2/8/08, the physician ordered a 1 to 1 sitter due to "the patient being at risk for pulling out tubes and decannulation and fall."</p> <p>Further record review revealed that on 4/22/08, at 6 p.m., Patient 1 had pulled out his tracheostomy tube. This was witnessed by the family of a patient in the same room, and they notified nursing staff. There was no documentation that there was a 1 to 1 sitter in the room.</p> <p>Review of the "Expiration Summary", dated 4/23/08, revealed that "the patient had an event</p>	E1899	<p>sitters as ordered by the physician. The NS documents on the daily staffing sheet and Sitter Log the name of the staff member assigned to sit with a patient. Any variances are immediately reported to the Chief Clinical Officer (CCO) and/or Administrator on Call. The HS makes rounds three times per shift to validate the designated staff are at the patient's bedside. The CCO shall review all daily staffing assignments to ensure compliance with safe staffing practice.</p> <p><u>Monitoring:</u> The Quality Council (QC) will review the results of the monitors on a monthly basis. At the end of a three-month period, the QC will report results and recommendations to the Governing Board to determine the need for further monitoring based on any trends or patterns.</p> <p><u>Responsibility:</u> Chief Clinical Officer</p>	

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E1899	<p>Continued From page 2</p> <p>on the day before the date of expiration on 4/22/08. The patient managed to pull out his own tracheostomy; however, respiratory technicians were able to put the tracheostomy back. A one-to-one sitter had been called and the patient had a one-to-one sitter in the facility. " Review of the census for the day of the incident, on 4/23/08, at 5:50 a.m., revealed there were five patients in the room requiring care and only one aide assigned to the room. During an interview with the Director of Nurses (DON) conducted on 9/26/08, at 11:30 a.m., revealed the following account of the event that occurred on 4/23/08. " The patient was very confused and agitated. The certified nurses' aide (CNA 1) was working in the room. She noticed that the patient had pulled out his tracheostomy and she attempted to reinsert it. " When the DON was asked if reinserting a tracheostomy tube was part of a CNA's job description, she stated, " No. " When asked if the CNA had been trained in reinserting a tracheostomy, she also replied, " No. " The DON stated that CNA 1 should have called out for help as soon as she discovered the patient in distress. The DON added that at this same time, the registered nurse (RN) came into the room to collect intake and output data, and that is when the CNA told the RN that the patient had pulled out his tracheostomy tube. The DON stated that " To my knowledge, the one-to-one sitter order had been implemented. " She stated that the House Supervisor was to carry out the order and ensure staff was made available for to do the one-to-one. The DON added, that " On occasion, there was one aide assigned to the room to care for all five patients. The House Supervisor would make this decision if there was a call-off.(a scheduled person not</p>	E1899		

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E1899	<p>Continued From page 3</p> <p>being able to work) " When the DON was asked if the House Supervisor had advised her when the one-to-one sitter was not available due to staffing problems, she stated that they should have, but further added that they did not do so. The DON was asked if the physician should have been notified when the facility had failed to carry out his order for a one-to-one sitter, she stated, " Yes " , but indicated that he had not been notified. An interview with an administrative staff (administrative staff 1) was conducted on 9/26/08, at 10:25 a.m. The administrative staff member revealed that upon the facility ' s investigation of this incident, CNA 1 was interviewed. CNA 1 stated that she had been caring for patients in beds A, B, C, D, and E that morning. She stated to the investigator, that she had been cleaning bed D and noticed that Patient 1 was moving around in the bed a lot. She then started to clean bed E. CNA 1 reported that it took her about 20 minutes to clean bed E. After she took the dirty linens to the hamper in the bathroom, she noticed that Patient 1 did not look good. She stated that she yelled for the RN, and went over to the patient and tried to replace the tracheostomy tube back in the patient ' s throat. Administrative staff 1 was asked if the 1 to 1 sitter order had been carried out, she replied that she " did not think so, but would have to review the staffing records. " The staffing records for the facility and the unit the patient was on, was requested for the time period of 2/08 through 4/08.</p> <p>Review of the facility staffing reports indicated that the facility rarely provide an actual 1 to 1 sitter for the patient, despite the staffing record stating " sitter " for that patient room. On the days that " sitter " for the room was documented, the number of aides actually</p>	E1899		

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E1899	Continued From page 4 working on the unit did not allow for an extra aide to be a one-to-sitter. The "sitter" aide was actually assigned to care for all of the patients in the 5-bed patient room.	E1899		