CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

Amended 2567 + POC Accepted 12/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050663	A. BUILDING _____ B. _____	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Angeles Community Hospital	4081 E Olympic Blvd, Los Angeles, CA 90023-3330 LOS ANGELES COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00341616 - Substantiated Representing the Department of Public Health: Surveyor ID # 27811, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.3: 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. Amended 12/11/15 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. T22 DIV5 CH1 ART6- 70413 (a) Basic Emergency Medical Service, Physician (a) Written policies and procedures shall be		**A 000 Initial Comments** Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusions set forth on the Statement of Deficiencies. This credible allegation of correction is prepared and executed solely because it is required by federal/state law. Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. A Policy Titled: *Policies and Procedures Development and Revision* was revised to include the following elements: the person responsible for the service in consultation with other appropriate health professionals and Administration, and policies were approved by the governing body, procedures shall be approved by the administration and medical staff where such is appropriate. **See Attachment A**	2/2014

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Richard Wershba TITLE: Chief Executive Officer (X6) DATE: 12/22/2015

By signing this document, I am acknowledging receipt of the entire citation packet Page(s) 1 thru 5

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate. Based on record review and interview, the facility failed to implement its policies and procedures on classification and management of a patient with chest pain in the emergency room (ER). The facility failed to provide oxygen and cardiac monitoring for Patient 1 who was experiencing chest pain. Patient 1 went to the bathroom after a registered nurse had completed assessing the patient. Patient 1 was then found non-responsive on the bathroom floor. Resuscitative measures were instituted and were unsuccessful. The Certificate of Death indicated Patient 1 died of cardiac arrest (sudden stop of heart function), followed by respiratory arrest (sudden stop of normal breathing due to failure of the lungs to work effectively) and acute myocardial infarction (heart attack). Findings: On May 8, 2013, an unannounced visit to the facility was conducted to investigate a complaint regarding Patient 1's death.		The Chest Pain Protocol/Policy was revised and approved in Feb. 2014, and supersedes the referenced policy of 2003. The revised protocol has been built into the electronic medical record. **See Attachment B** The Triage Process Policy was revised in Oct. 2015 and supersedes the previous Triage policy of 2005. The revised policy clearly outlines the steps of the triage process along with definitions of the 5 levels of emergency severity index (ESI). **See Attachment C** In addition to the earlier education provided to the staff following this event, we have completed additional comprehensive training on the Chest Pain (CP) Protocol and Triage Process Policy for all Physicians and Nurses in the ED. The sessions were also open to all other staff. **See Attachment D** The CP Protocol training embodied the following content: classification and Management of a patient with chest pain in the ED. Patients presenting with symptoms suggestive of Acute M.I. will be classified as emergent and will be placed on ECG monitoring without delay and evaluated by the emergency physician as soon as possible. This will be done prior to registration and without regard to financial status. Patients with a complaint of suspected chest pain based on assessment, or who display signs and symptoms of chest pain will be treated as	12/2015 12/2015 12/2015

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	On May 8, 2013 at approximately 8:30 a.m., Patient I's medical record was reviewed. The ambulance service record dated January 2, 2013, revealed that at 11:40 p.m., Patient 1 was transported to the facility for reports of chest pain. According to the ambulance record, Patient 1 stated he was experiencing chest pain at a level of 10 out of 10 (worst pain experienced based on Wong-Baker pain scale). The ambulance record indicated the patient's care was transferred to the facility's ER at 12:26 a.m. A review of the facility's Emergency Registration sheet indicated Patient 1 was admitted to the ER on January 3, 2013 at 12:35 a.m., with the chief complaint of shortness of breath and chest pain. According to the American Heart Association, chest pain is a symptom of a possible heart attack that is caused by a lack of oxygen to the heart muscle. A review of the Emergency Room Register indicated Patient I's condition was classified as "Urgent" on January 3, 2013 at 12:35 a.m. A review of an Emergency Department Patient Care Record (EDPCR) dated January 3, 2013 at 12:35 a.m., indicated the registered nurse had assessed the patients chest pain as constant pain, non-radiating, pain intensity was 10 and described as "pulling" pain. After the assessment was completed, the patient wanted		acuity is determined according to the stability of vital functions and potential for life, limb or organ threat. The CP Protocol is inclusive of: cardiac monitoring, establishment of intravenous line and fluids, obtaining a 12-lead EKG (within 5 min. of arrival or complaint), application of oxygen therapy and continuous pulse oximetry, cardiac enzymes, notification of primary care physician, and repeat EKG if first 12-lead EKG was inconclusive (not diagnostic for ST elevation/LBBB) and the patient complains of chest pain, and evaluation for higher level of care and arrangement for appropriate level of transportation. The Triage Policy Training embodied the following: to provide a process by which an ED nurse provides prompt evaluation of all patients entering the ED and determines priorities of care. The 5 ESI's: 1. Level 1 – resuscitation 2. Level 2 – Emergent 3. Level 3 – Urgent 4. Level 4 – Semi-Urgent 5. Level 5 – Non-Urgent Steps of the Triage Process: 1. Screening by an RN upon arrival to the ED 2. Patient Interview with triage assessment performed by an RN 3. Data Processing, to include validation of acuity with initiation of appropriate measures. Reassessment – determined by	

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	to go to the bathroom because he felt nauseated. A review of an Emergency Provider Record dated January 3, 2013, indicated the patient went to the bathroom at approximately 12:50 a.m. A review of the ER records did not disclose evidence that Patient 1 was provided oxygen or heart monitoring on January 3, 2013, between 12:26 a.m. and 12:50 a.m., a span of approximately 24 minutes. According to the Emergency Provider Record dated January 3. 2013, Patient 1 was heard vomiting inthe restroom at approximately 12:50 a.m. The bathroom door was opened by a nursing staff member and the patient was found non-responsive on the floor. The Emergency Provider Record indicated resuscitative measures were implemented at 12:55 a.m. and stopped at 1:20 a.m., for approximately 25 minutes. The resuscitative efforts were unsuccessful and the patient was pronounced dead at 1:20 a.m. A review of the Certificate of Death indicated Patient 1 died on January 3, 2013. The immediate "cause of death" was cardiac arrest, followed by respiratory arrest, and acute myocardial infarction. On May 8, 2013, when interviewed at 11:10 a.m., the director or nurses stated the patient		1. Updating family members of the patient's condition. 2. Updating the order in which patients are medically screened and treated based on department activity and/or any changes in the patients condition. *Monitoring* Ongoing monitoring will occur to assure that ED nurses and physicians document their assessments of patients seeking emergency care and are triaged appropriately based on presenting signs and symptoms. Audits will occur weekly X4 weeks, and then monthly X3 Months. Compliance will be presented at monthly Quality Council meetings for a minimum of 4 months, or until full compliance is achieved. See attached tool for monitoring. **See Attachment E** *Person Responsible* Chief Nursing Officer Physician Medical Director	

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	should have been classified as "Emergent" and the patient should have been given oxygen and his heart should have been monitored with an electrocardiogram. A review of the facility's policy and procedure titled, "Nursing Triage" and dated February 1, 2005, stipulated the patients presenting with chest pain would be classified as "Critical" which is "the most emergent of conditions." The facility's policy further stipulated that patients who are classified as "Critical" "could experience loss of life or function if immediate intervention was not instituted." A review of the facility's policy and procedure titled, "Patient Management of: Patient With Chest Pain" dated March 2003 stipulated that in order to initiate immediate life-saving care for the patients complaining of chest pain, the patients presenting with chest pain would be placed in an ER bed immediately, placed on oxygen, and their heart would be monitored by an electrocardiogram. The facility's failure to follow its policies and procedures regarding the classification and management of a patient with chest pain, is a deficiency that has caused or likely to cause serious injury or death to the patient, and therefore, constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1.			