

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555522	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2008
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NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL OF SAN BERNARDINO D/P SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 1805 MEDICAL CTR DR., SAN BERNARDINO, CA 92411 SAN BERNARDINO COUNTY
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	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit:</p> <p>CLASS AA CITATION -- PATIENT CARE 24-1887-0008216-S Complaint(s): CA00143412</p> <p>Representing the Department of Public Health: Surveyor ID # 22232, HFEN</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>REGULATION VIOLATION: Title 22 72311 - Nursing Services - General 72523 Patient Care Policies and Procedures</p> <p>72311 (a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission.</p> <p>The facility failed to ensure patient care included a continuing assessment of Patient 1, which would include input from health professionals involved in</p>			

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

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	<p>Continued From page 1</p> <p>the patient's care. The facility failed to ensure nursing and respiratory therapy staff provided a continued assessment of Patient 1's respiratory status, which included the patient's respiratory ventilator equipment.</p> <p>72523 (a) Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved.</p> <p>The facility failed to ensure the policy and procedure pertaining to ventilator equipment, specifically, alarm settings, was consistently implemented. On February 2, 2008 at 7:25 AM, Patient 1 was observed without respirations; no chest rises and falls were noted. The patient's ventilator gauges showed abnormal readings and the ventilator alarm was not audible. The ventilator tubing was found disconnected. Patient 1 expired on February 2, 2008 approximately 15 minutes later.</p> <p>On March 20, 2008 at 3:55 PM, an unannounced visit was made to the facility to investigate an event regarding a ventilator (machine that breathes for or assists a patient to breathe) dependent patient becoming disconnected from the ventilator and dying shortly thereafter.</p> <p>Patient 1 was admitted to the facility on July 27,</p>		<p>Corrective Action:</p> <p>In June 2008, following the event cited, the Directors of Nursing and Cardiopulmonary in collaboration with Education provided inservice education to 100% of the clinical staff related to care of the ventilated patient and ventilator management. The objectives of the course included knowledge of ventilator circuit and alarm management.</p> <p>By May 30, 2011, 100% of clinical and respiratory staff will receive repeat and updated education related to the following</p> <ol style="list-style-type: none"> 1. ventilator management, 2. circuit management, 3. alarm management 4. documentation of continued assessment after change in respiratory status 5. Documentation of ventilation check according to policy. 	<p>6/2008</p> <p>5/30/2011</p>

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	<p>Continued From page 3</p> <p>At 7:55 AM, LVN 1 documented, "RT came out of the room stating the patient had no V/S (vital signs). I went back in the room and verified no V/S. Charge nurse notified".</p> <p>On February 2, 2008 at 8:10 AM, the RN documented, "Pt without BP (blood pressure), P (pulse), spontaneous respirations. Pupils fixed. No response to sternal rub. Pronounced dead..".</p> <p>On March 20, 2008, during review of the "Neurological Care Unit Mechanical Ventilation Record" dated February 2, 2008, the following "late entry" (documentation entered at a time later than the care was performed) for 7:25 AM, indicated the ventilator check was completed. On the back side of the form, the narrative, completed by RT 2, showed, "Received pt from NOC (night) shift on documented settings. 0725 LVN 1 called myself and (RT 1) to pt room because pt did not look right. Upon entry into the room the vent circuit was confirmed and I assessed the pt and confirmed ventilator settings and function. 0745 Upon entry into the room the pt was found pulseless and with no heart sounds. RN notified."</p> <p>On March 25, 2008 at 11:15 AM, a telephone interview was conducted with RT 1. RT 1 stated a nursing staff member asked the RT to come to Patient 1's room to check on him. RT 1 stated upon entering Patient 1's room at approximately 7:15 AM on February 2, 2008, there was no rise and fall chest movement of Patient 1. RT 1 stated the ambu bag (a bag connected to oxygen to assist</p>		<p>Responsible Person: The Facility Administrator is responsible to ensure compliance and will report results to Medical Director and Quality Council monthly until 100% compliance has been achieved and sustained.</p>	

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	<p>Continued From page 5</p> <p>RT 2 further stated that a ventilator check had not been done yet and that the last documented "vent check" had been at about 3:00 AM. RT 2 further stated, the Respiratory Care Manager, "made me write the vent check" when the ventilator check had actually not been done.</p> <p>On April 7, 2008 at 10:15 AM, an interview was conducted with LVN 1, the LVN provided care to Patient 1 on February 2, 2008. LVN 1 stated that during the change of shift report, CNA1 summoned LVN 1 to Patient 1's room. CNA 1 stated the patient was not very responsive. LVN1 further stated she went to the patient's room, checked the patient's pulse and vital signs, which she stated were stable. LVN 1 stated there were no machine alarms sounding. LVN 1 stated that increased flaccidity (increased muscle weakness), which was noted from the day before, was observed.</p> <p>LVN 1 stated 2 RT's were informed of the concerns; LVN 1 left the RT's with the patient. LVN 1 continued to state that 15 minutes later, one of the RT's informed the LVN that the ventilator had been "unplugged".</p> <p>LVN 1 then stated that at 8:00 AM, Patient 1 was noted to have no vital signs. LVN 1 notified the charge nurse, who responded and went into the patient's room.</p> <p>On February 2, 2008 at 8:10 AM, Patient 1 was pronounced dead.</p> <p>On April 9, 2008 at 10:40 AM, an interview was</p>				

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	<p>Continued From page 6</p> <p>conducted with CNA 1. CNA 1 stated she was familiar with Patient 1, as she had cared for him many times before. CNA 1 then stated the patient was "different" from other days, "his eyes would not open" and he seemed "weird" to her. CNA 1 stated she then requested LVN 1 to come to the room to check the patient. CNA 1 stated she didn't think the patient "was o.k." CNA 1 stated LVN 1 came to the patient's room and said, "He's o.k." CNA 1 stated she responded, "Not to me" and stayed in Patient 1's room for 10 to 15 minutes, observing the patient. CNA 1 stated that there was not an audible ventilator alarm sounding during the time she was in the room.</p> <p>CNA 1 stated she called LVN 1 to Patient 1's room a second time to check the patient's condition. LVN 1 returned to the room and then called for RT assistance. CNA 1 stated she left the room when RT came to the room.</p> <p>Record review of the facility's "Respiratory Procedures Provided by Licensed Nursing Staff in NCU" was conducted on April 9, 2008. Documentation showed, under Policy: 3.0, licensed personnel will demonstrate appropriate competence in VENTILATOR TROUBLE-SHOOTING...4.0 Nursing staff will demonstrate competency annually."</p> <p>An interview was conducted on April 9, 2008 at 10:50 AM, with the Director of Nurses (DON). She stated, "Yearly competencies are conducted on ventilator management". However, the DON was unable to provide completed proof of LVN 1's</p>			

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	<p>Continued From page 8</p> <p>"It is the policy of this facility to determine the resident's peak airway pressure; check the high and low pressure alarm settings; and adjust the alarm settings to maintain (the above) parameters every 4 hours."</p> <p>In addition, the policy stipulated to check the patient's peak airway pressure every four hours and adjust the alarm settings as needed to maintain the parameters and document the ventilator alarm settings in the patient's record.</p> <p>The facility's document, "Ventilator Alarm Classification and Setting," under "Ventilator Alarm Classifications," stated: Level 2 Non-critical Ventilator Malfunction Level 2 alarms may be potentially Life-threatening. Level 2 alarms provide both visual and audio alarms, which are non-continuous. The audio alarm will cease, if the condition is resolved.</p> <p>The alarm may be cancelled or reset by the clinician. Examples of level 2 Alarms include: circuit leak, circuit blockage, pressure, volume and PEEP alarms are set and maintained by the clinician..."</p> <p>Based on the information obtained, the facility failed to ensure only staff trained and proficient in caring for ventilator dependent patients, care for them. The facility failed to ensure staff caregivers maintained yearly competency, as stipulated in their policy and procedure. In addition, the facility failed to ensure staff performed ventilator checks every four hours as required. Additionally, the facility failed to ensure patient care included a</p>			
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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.