

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2013
NAME OF PROVIDER OR SUPPLIER COUNTRY VILLA BELMONT HEIGHTS HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1730 Grand Ave, Long Beach, CA 90804-2011 LOS ANGELES COUNTY		
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	<p>into the stomach through the skin and the stomach wall to provide nutrition and medications) which had been inserted for the first time on [REDACTED]/10, received the appropriate treatment and services to prevent complications by failing to:</p> <p>Implement the facility's policy and procedures that indicated to insert the GT only as per physician's order, not to reinsert a new GT (less than four weeks old) and not to replace a PEG [percutaneous (procedure performed through the skin) endoscopic gastrostomy] tube.</p> <p>On [REDACTED]/10 at 1:30 p.m., after the patient pulled out the GT and one day after the GT surgical insertion, License Vocational Nurse 1 (LVN 1), reinserted a new GT and resumed the feeding formula. On [REDACTED]/10, 5:50 a.m., (sixteen hours after the GT reinsertion), the patient had coffee ground vomit, elevated temperature, rapid heartbeat and low blood pressure. The patient was transferred to General Acute Care Hospital 2 (GACH 2) where she was diagnosed with acute peritonitis (inflammation of the membrane which lines the inside of the abdomen and all of the internal organs) secondary to GT displacement into the peritoneal cavity (a space between the layers of the peritoneum (serous membrane lining the walls of the abdominal and pelvic cavities) and septic shock (is a serious condition that occurs when an overwhelming infection leads to life-threatening low blood pressure). Patient 1 remained in GACH 2 until [REDACTED]/10, [REDACTED] [REDACTED] after admission) when she expired at [REDACTED] p.m. Patient 1 expired [REDACTED] [REDACTED] after the GT was inserted by LVN 1.</p>		<p><u>Corrective Action for Affected Resident</u></p> <p>Patient # 1 was transferred to the hospital on [REDACTED] 2010 and eventually expired on [REDACTED]/10.</p> <p>One on one education and training on Gastrostomy & Jejunostomy Placement and Patency Check, Dislodging/Pulling out policy and procedure and Skills competency check to verify correct tube placement and patency of Gastrostomy Tube, PEG and Jejunostomy was done with LVN # 1 on 3/31/2013</p> <p>LVN # 2 is no longer employed at the facility</p> <p><u>Procedure for Identifying Potentially Affected Residents and Corrective Action</u></p> <p>There are no other residents affected by the same practice as the facility's Gastrostomy & Jejunostomy Placement and Patency Check, Dislodging/Pulling out policy and procedure was revised on 1/25/12. Revised policy does not allow GT, PEG and JT re-insertion at the facility regardless of the age of the GT, PEG and JT. Should a GT, PEG or JT be pulled accidentally and/or dislodged; the physician will be notified by the Licensed Nurse for further instructions.</p>	

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	<p>On 12/4/12, a review of Patient 1's clinical record revealed the patient was a [redacted] years old [redacted], initially admitted to the facility from GACH 1 on [redacted]/09, and readmitted [redacted]/09, with diagnoses including [redacted] [redacted] [redacted] [redacted], [redacted] tube (NGT- [redacted] inserted through the [redacted] for the purpose of nutrition and medication administration) and advanced [redacted] (loss of [redacted] function).</p> <p>The Minimum Data Set (MDS - a standardized assessment and care planning tool) dated [redacted]/08, indicated the patient was moderately impaired in her [redacted] [redacted] for daily decision-making (decisions poor, cueing needed), required extensive to total assistance with all activities of daily living (ADLs) and received nutrition only through the NGT.</p> <p>A physician's order dated [redacted]/09, indicated to give the feeding formula Novasource Renal at a rate of 45 cubic centimeters (cc) per hour, to provide 810 cc, 1620 kilocalories (kcal) in 18 hours per day, by the way of a feeding pump. All medications were ordered to be administered through the NGT. A physician order dated [redacted]/09, indicated to flush the feeding tube with 300 cc of water every six hours. On [redacted]/10, the physician ordered a PEG placement (to replace the feeding tube from a NGT to a GT) to be performed on [redacted]/10, at GACH 1.</p> <p>According to the nursing notes on [redacted]/10, at 7:30 a.m. the patient went to GACH 1 and returned back to the facility the same day at 5:30 p.m. with the</p>		<p>In house residents with GT, PEG and JT will be assessed by the RN Supervisors, ADON and DON to ensure GT is in the proper place, identify signs and symptoms of infections and complications of Gastrostomy Tube. Physician will be informed immediately if any resident is affected for proper intervention.</p> <p><u>Measures Adopted for Systemic Change</u></p> <p>On 1/30, 2012 and 1/31/2012, the Licensed Nurses were provided with in-service on the revised Gastrostomy & Jejunostomy Placement and Patency Check, Dislodging/Pulling out policy and procedure by the Director of Staff Development.</p> <p>Licensed Nurses will be re-educated on the facility's Gastrostomy & Jejunostomy Placement and Patency Check, Dislodging/Pulling out policy and procedure by the Resource Nurse Consultant and/or Director of Nursing on or before June 3, 2013.</p> <p>Licensed Nurses will be educated by the Resource Nurse Consultant and/or Director of Nursing on the signs and symptoms of GT displacement including physician notification for change of condition on or before June 3, 2013.</p> <p>Licensed Nurses will be educated by the Resource Nurse Consultant and/or</p>	

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	<p>new GT. The stoma (insertion) site had a dry dressing and the patient had no discomfort. A nursing note dated [REDACTED] 10, 11 p.m. to 7 a.m. shift, timed at 6:30 a.m., indicated the patient had no signs and symptoms of respiratory or cardiac distress, the GT stoma site had no bleeding, the patient was tolerating GT feeding well and the tube was flushed with water as ordered. According to a nursing note dated [REDACTED] 10, timed at 1:30 p.m., LVN 2 documented the patient removed the GT, an order was obtained to reinsert the GT, the GT was replaced and all medications were given and tolerated. Nursing notes dated [REDACTED] 10, timed at 11 p.m., and at [REDACTED] 10, timed at 12:30 a.m., indicated the patient tolerated the GT feeding well.</p> <p>A nursing note dated [REDACTED] 10, timed at 5:50 a.m., indicated the patient had a coffee ground vomit, had a body temperature of 101.2 degrees Fahrenheit and cooling measures were provided. The blood pressure was 80/64 (millimeters of Mercury -mmHg) and the heart rate was 122 (heart beats per minute). Normal vital signs are: blood pressure-120/80mm/Hg; heart rate 60-80 beats per minute; and temperature 97.8- 99.1 degrees Fahrenheit (National Institute of Medicine/National Institutes of Health website: www.nlm.nih.gov/medlineplus/ency/article/002341.htm).</p> <p>The nursing note further indicated Physician 1 was called and a message was left. At 6 a.m., the on-call physician called back, was made aware of the patient's condition and ordered to transfer the patient to GACH 1</p>		<p>Director of Nursing to prevention and/or minimizing complications of Gastrostomy tube, recognizing signs and symptoms of infections including immediate interventions on or before June 3, 2013.</p> <p>Skills competency check to verify correct tube placement and patency of Gastrostomy Tube, PEG and Jejunostomy will be done to the Licensed Nurse by the Director of Nursing and/or designee on or before June 3, 2013.</p> <p>Skills competency check to verify correct tube placement and patency of Gastrostomy tube, PEG and Jejunostomy, prevention of complications will be incorporated on the orientation process of the licensed nurses. Director of Staff Development and/or designee will be responsible to ensure skills competency check is completed before the new hired licensed nurse is assigned to administer medication and feeding via Gastrostomy Tube.</p> <p>Licensed Nurses Skills competency on checking of GT placement and in-service on the Gastrostomy & Jejunostomy Placement and Patency Check, Dislodging/Pulling out policy and procedure will be done annually and as needed by the Director of Staff Development and/or Designee</p> <p>The Administrator and /or designee will validate through review of the</p>	

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	<p>A late entry nursing note written by LVN 1 dated [REDACTED]/10, timed at 8 a.m., for [REDACTED]/10 (without time specified) indicated she assisted the charge nurse (LVN 2) with the GT replacement and inserted a 20-French GT to the abdominal stoma and a small amount of bleeding was noted. LVN 1 also documented Nurse Practitioner 1 was in the building, was aware the patient pulled out the GT, and ordered to re-insert the GT as needed.</p> <p>A review of the physician's telephone orders revealed an order obtained by LVN 1 [REDACTED]/10, no time stated, indicating Physician 1 ordered to re-insert GT size 20 French /30 cc as needed if dislodged/pulled out. However, the telephone order was not signed by Physician 1 and had a hand written note stating, "I did not give this order - cannot sign."</p> <p>In addition, there was no documented physician's order to resume the administration of enteral feeding (feed delivered directly into the stomach) after the patient returned to the facility after the PEG procedure on [REDACTED]/10.</p> <p>According to the ambulance Medical Transport form dated [REDACTED]/10, at 6:48 a.m., the patient's blood pressure was 80/48 and the heart rate was 132. At 7:02 a.m., the blood pressure was 63/49 and the heart rate was 141. The patient required emergency transportation and the transfer was diverted to GACH 2 (nearest hospital).</p> <p>According to the clinical record from GACH 2, while in the ER on [REDACTED]/10, a chest x-ray was performed</p>		<p>newly hired licensed nurse personnel file or through interviews to ensure skills competency is completed.</p> <p>The Director of Nursing and the Administrator will be responsible to ensure compliance.</p> <p><u>Monitoring of Corrective Action and Quality Assurance</u></p> <p>The Resource Nurse Consultant, during facility visit will conduct random interview to licensed nurses to validate their knowledge on the Gastrostomy & Jejunostomy Placement and Patency Check Dislodging/Pulling policy. Outcome of interviews will be communicated to the DON and/or Administrator for further follow through.</p> <p>The Administrator and/or Director of Nursing Services will provide a summary trend analysis of the findings from audits to the facility's monthly Continuous Quality Improvement Steering Committee for further evaluations and recommendations.</p> <p>Compliance date: June 3, 2013</p>	

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	<p>which indicated pneumoperitoneum (air or gas in the peritoneal cavity), and an abdominal x-ray indicated the GT appeared to be in the region of the stomach and recommended a computed tomography (CT) scan (an imaging method that uses x-rays to create pictures of cross-sections of the body) to confirm. The patient was transferred to the intensive care unit where at 10:50 a.m., had a cardiac arrest (heart stops beating) and was resuscitated.</p> <p>The History and Physical dictated [REDACTED] 3/10, indicated there was suspicion the patient had a perforated viscous (rupture of an abdominal organ) and a surgical consultation was obtained. The patient had a Code Blue (medical emergency to revive an individual in cardiac arrest), was intubated (placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway] and placed on a ventilator (machine that supports breathing). The diagnostic impression included possible perforated viscous and displaced GT.</p> <p>A Surgical Consultation dated [REDACTED] /10, indicated the patient's abdomen was tender and had a GT in the left upper quadrant with what appear to be tube feeding draining around it. The impression diagnoses included cardiac arrest upon arrival to the intensive care unit, septic shock, and suspicion the GT was not in the stomach but in the free peritoneal cavity. The patient was not a surgical candidate.</p> <p>According to the Death Summary dates [REDACTED] 10, the patient was suspected to have a perforated viscous (rupture of an abdominal organ) and a CT</p>			

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	<p>scan of the abdomen could not be done because of the patient's critical state. The patient remained critically ill with poor prognosis and expired on [REDACTED] 10. The impression diagnoses included acute peritonitis secondary to GT displacement into the peritoneal cavity, septic shock and renal failure.</p> <p>According to the Certification of Vital Record, Certificate of Death - Physician/Coroner's Amendment, the patient expired on [REDACTED] 10, at 3:24 p.m. The first three listed causes of death diagnoses were [REDACTED] [REDACTED] [REDACTED] and [REDACTED] [REDACTED] into [REDACTED] cavity.</p> <p>On 12/4/12, a review of the personnel file disclosed LVN 1 was hired on 7/23/09, and had no documented evidence an enteral feeding and GT care competency check was done. There was also no evidence of training related to GT care.</p> <p>On 12/4/12 at 2 p.m., an interview with the Director of Staff Development (DSD) regarding LVN 1's competency to insert GT was conducted. The DSD stated she was unable to find documentation to indicate LVN 1 had received any type of training and skill evaluation related to the care and insertion of GTs during her employment in the facility.</p> <p>On 12/21/12 at 2 p.m., a telephone interview with Nurse Practitioner 1's supervisor was conducted. The supervisor explained it was against company (Health Maintenance Organization - HMO) policy and procedure for support nurses (LVNs or registered nurses - RNs) to reinsert GTs. Also a</p>			

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	<p>nurse practitioner would not give such order without the physician's authorization.</p> <p>On 12/26/12 at 11:04 a.m., a telephone interview with Physician 1 was conducted. Physician 1 stated she would never give an order to have a nurse insert a GT and would not even reinsert the GT herself. She also stated the facility's nurse should have sent the patient to the hospital for the GT reinsertion.</p> <p>On 12/26/12 at 2 p.m., during an interview followed by a written declaration, LVN 1 stated she was the treatment nurse on █10, during the 7 a.m. to 3 p.m. shift and she re-inserted the GT using a house supply size 20 French tubing into the patient's stomach. LVN 1 stated she performed the procedure without any problems, checked the GT for placement and residual and the patient appeared, "Okay." LVN 1 indicated she resumed the patient's feeding without any problem. LVN 1 stated she did not call Physician 1 because Nurse Practitioner 1 was in the building and gave a verbal order to reinsert the GT. LVN 1 stated the facility did not provide her with training regarding insertion of the GT.</p> <p>On 2/15/13 at 9:50 a.m., during a telephone interview, Nurse Practitioner 1 stated she could not remember if she gave the verbal order to LVN 1 to reinsert the patient's GT.</p> <p>According to the facility's policy and procedure on Gastrointestinal Tube Change and Reinsertion dated 12/2000, gastrointestinal tubes will be</p>			

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	<p>changed and reinserted, per physician's order, in patients with established tracks in order to maintain patency for nutritional maintenance. The procedures indicated to obtain a physician's order. The policy further noted it was recommended a new GT (less than four weeks old) not to be reinserted by facility licensed nurses and PEG tubes should not be removed or replaced by a licensed nurse at the facility.</p> <p>The facility failed to ensure Patient 1, who was fed by a GT, which had been inserted for the first time on █/10, received the appropriate treatment and services to prevent complications by failing to:</p> <p>Implement the facility's policy and procedures that indicated to insert the GT only as per physician's order, not to reinsert a new GT (less than four weeks old) and not to replace a PEG tube.</p> <p>On █/10 at 1:30 p.m., after the patient pulled out the GT and one day after the GT surgical insertion, LVN 1 reinserted a new GT and resumed the feeding formula. On █/10, 5:50 a.m. (sixteen hours after the GT reinsertion), the patient had coffee ground vomit, elevated temperature, rapid heartbeat and low blood pressure. The patient was transferred to GACH 2 where she was diagnosed with █ secondary to █ displacement into the █ and shock. Patient 1 remained in GACH 2 until █/10, (seven days after admission) when she expired at █ p.m. Patient 1 expired nine days after the GT was inserted by LVN 1.</p>			

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	<p>The above violation presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result and was a direct proximate cause of the death of Patient 1.</p>			

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