

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/20/2012	
NAME OF PROVIDER OR SUPPLIER COUNTRY VILLA TERRACE NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6070 W Pico Blvd, Los Angeles, CA 90035-2647 LOS ANGELES COUNTY		
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	<p>that residents receive proper treatment and care for the following special services: Parenteral and enteral fluids.</p> <p>On February 2, 2012 at 12 p.m., an unannounced visit was made to the facility to investigate an entity reported incident (ERI), and two complaints from different sources regarding Resident 1's jejunostomy tube (J-tube, a special feeding tube surgically inserted through an incision in the upper abdomen, that permits enteral feeding and insertion of medications and nutrients for the Resident). Resident 1's J- tube, according to the complaints, was replaced with an incorrect type of tube which after being placed in the intestine and inflated, caused an intestinal obstruction (blockage of contents of the intestine).</p> <p>Based on interview and record review, the licensed nursing staff failed to ensure that Resident 1 who was admitted with a jejunostomy feeding tube received appropriate treatment and services, including but not limited to:</p> <ol style="list-style-type: none"> 1. Failure to ensure the entry site and correct type of Resident 1's feeding tube was accurately identified upon admission. 2. Reinsertion of Resident 1's feeding tube without a physician's order, in violation of the facility's policy and procedure. 		<p>Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceeding on that basis</p> <p>CLASS AA CITATION - Patient Care 91-1746-0011245-F</p> <p>Resident 1 was transferred to Cedar Sinai Medical Hospital on January 16, 2012 for evaluation and the resident did not return to the facility.</p> <p>On 2/2/12 the Director of Nursing (DNS) and (IDT) Interdisciplinary Team reviewed the other resident's who has the potential to be affected</p>	

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	<p>According to the admission record, Resident 1 was admitted to the facility on December 21, 2011, with diagnoses that included dysphagia (difficulty swallowing) and status post (after) gastrostomy (a surgical procedure for inserting a tube through the abdominal wall, into the stomach).</p> <p>A review of the Nursing Admission Assessment narrative notes, dated December 21, 2011, indicated the resident's diagnoses included status post gastric resection (surgical removal of part or all of the stomach) due to ischemia (insufficient supply of blood to an organ) with esophagogastrectomy (partial removal of the lower esophagus [lower esophagus carries food, liquids and saliva from your mouth to the stomach]), aspiration pneumonia (infection of the lungs caused by food, saliva, liquids or vomit breathed into the lung), and had a gastrostomy tube (GT) feeding intact and patent (unobstructed).</p> <p>A review of the GACH Discharge Medication List dated December 21, 2011, obtained from Resident 1's Skilled Nursing Facility (SNF) clinical record indicated Resident 1's medications were being administered through the J-tube.</p> <p>A review of the Minimum Data Set (MDS - a standardized assessment care and screening tool), dated December 29, 2011, indicated the resident sometimes made self-understood and had the ability to understand others. The resident's cognitive skills for daily</p>		<p>with the same deficient practice. No residents were identified on Jejunostomy tube. The governing body has revised its policy and procedure of Gastrostomy, Jejunostomy tube placement, patency check, dislodging and pulling out on 1/25/12. The facility has implemented the new policy, which specifies that the facility staff would not attempt to reinsert the G-tube, PEG, or J-tube but rather call the physician for further instruction. The Administrator on record at the time of the incident reported to the Board of Registered Nurses, as well as the Board of Vocational Nursing & Psychiatric Technicians the three licensed nurses involved in the incident on 1/27/12.</p> <p>The Director of Staff Development (DSD) and/or Director of Nurses (DNS) will provide inservice training to licensed nurse (RN, LVN) about the Class AA Citation deficiency</p>	

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	<p>decision-making were moderately impaired and the resident had a feeding tube.</p> <p>The resident had a physician's order, dated December 21, 2011, for Peptamen nutritional formula 1.5 at 65 cubic centimeters (cc) per hour for 18 hours to provide 1170 cc/1755 calories per 24 hours.</p> <p>The Clinical Notes Report, dated January 16, 2012 at 1:33 p.m., indicated Resident 1 was noted with copious of green drainage from GT stoma (opening). The physician was called. At 1:54 p.m., the physician called back and gave an order for a wound culture and to call the resident's surgeon. At 2:04 p.m., the physician gave an order to transfer the resident to general acute care hospital (GACH) for a GT evaluation follow up.</p> <p>The Nurses Notes from the GACH, dated January 16, 2012 at 4:10 p.m., indicated the resident was admitted from SNF with a complaint of leaking from the GT with green output for one day. At 5:42 p.m. the documentation indicated the resident's GT had thick yellow drainage from stoma, and the surrounding skin was red. At 6:43 p.m., the documentation indicated the resident was actively vomiting with green bile colored vomitus. The resident's oxygen saturation level was less than 80 percent (normal range 95 to 100 %). The resident was tachycardic (had an excessively rapid heartbeat) to 120 beats per minute (bpm) (normal heart rate</p>		<p>including the plan of correction and facility's policy and procedure of Gastrostomy Jejunostomy tube placement, patency check, dislodging and pulling out. In addition, the inservice training will put emphasis on "If the Gastrostomy, PEG, and Jejunostomy Tubes are pulled out, the licensed nurse will not reinsert the tubing but will notify the physician immediately for further instruction, the licensed nurse will obtain IV hydration orders while waiting for the resident to be transferred to the acute care hospital for re-insertion". The training will start on 2/26/15 and will be completed by 3/6/15.</p> <p>On an on-going basis and every quarterly for one year the DSD and/ or designee will provide training and education to current and newly hired licensed nurses and the DNS will oversee to ensure the inservices are conducted as scheduled.</p>	

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	<p>ranges from 60 to 100 bpm). The documentation indicated the resident was placed on a non-rebreather mask (device primarily used to deliver oxygen to treat hypoxia, wherein the arterial blood oxygen saturation is less than 90 percent) at 15 liters per minute of oxygen.</p> <p>The Emergency Treatment Record from GACH, dated January 16, 2012, indicated the surgeon was consulted regarding the GT, and the resident was admitted to Intensive Care Unit (ICU -the department of a hospital that is designed and equipped for the monitoring, care, and treatment of the seriously ill patients).</p> <p>The Consultation Report, dated January 17, 2012, no specific time indicated the computed tomography (CT - detailed images of internal organs, obtained by sophisticated X-ray device) scan was significant for small bowel obstruction and bilateral pleural effusion (excess fluid filled space that surrounds the lungs).</p> <p>The complaint intake report, dated January 19, 2012, indicated the GACH's surgeon and the ICU attending physician reported finding an indwelling catheter (Foley catheter) tube with a balloon in the J-tube site that caused an obstruction. (A Foley catheter is a type of urinary drainage catheter, commonly inserted in the urinary bladder for urine drainage; this type of indwelling catheter tube has an</p>		<p>The licensed nurse will not reinsert the Gastrostomy, PEG, and Jejunostomy Tubes in the event when they are pulled out. The licensed nurse will notify the physician immediately for further instruction as per policy. The DSD will conduct skills competency to newly hired licensed nurses (RN, LVN) and will re-evaluate yearly and as needed. Any findings will be corrected immediately. The DSD will provide one on one education to specific licensed nurse and report to DNS for recommendations.</p> <p>The Director of Nursing will ask random questions to licensed nurses at least twice a month pertaining to the Class AA citation deficiency, with emphasis on the facility's policy and procedure of Gastrostomy Jejunostomy tube placement, patency check, dislodging and pulling out, to validate the skills competency of the licensed nurses. Any</p>	

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	<p>inflatable balloon used to maintain position of the catheter in the urinary bladder.) The GACH's surgeon stated he did not place this catheter tube upon the resident's last recent discharge from the GACH and the catheter is the wrong tube. The GACH suspected the catheter tube was replaced at the skilled nursing facility incorrectly.</p> <p>During an interview on February 10, 2012 at 12 p.m., with the 7 a.m., to 3 p.m., shift registered nurse (RN 1) supervisor, stated on January 15, 2012, upon leaving the facility, he observed certified nursing assistant (CNA 2) approach the 3 p.m., to 11 p.m., registered nurse (RN 2) supervisor. RN 1 stated RN 2 stopped him and informed him Resident 1's feeding tube was pulled out. RN 1 and RN 2 went to Resident 1's room and the 3 p.m., to 11 p.m., shift licensed vocational nurse (LVN 3) arrived into the room to assist. RN 1 stated RN 2 replaced the feeding tube with the indwelling urinary catheter French 18 (Foley type of catheter commonly used for urinary drainage). RN 1 stated he checked the feeding tube for placement by instilling 90 milliliter (ml) of air and listening to his stethoscope. RN 1 stated the feeding tube was in place and he observed gastric juice in the tubing. LVN 3 inflated the indwelling catheter's balloon with 20 ml of normal saline (salty water). RN 1 stated he checked the GT placement one more time by instilling 20 ml of air with a 60 ml syringe and auscultated to check for tube placement. RN 1 stated he did</p>		<p>findings will be addressed immediately to the DSD for re-training and education of the licensed nurse.</p> <p>The Quality Assurance Nurse will monitor monthly the facility's compliance with the above mentioned. Any identified findings will be addressed to the DNS and Administrator for follow up and immediate resolution.</p> <p>The DNS and/ or designee will provide a summary of the trend analysis to the monthly CQI meeting for recommendations and re-evaluation of monitoring process.</p>	

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	<p>not ask RN 2, if she called the physician, RN 1 stated the facility's policy is to notify the physician when a tube is replaced.</p> <p>During an interview on February 29, 2012 at 2 p.m., RN 2 supervisor stated on January 15, 2012, CNA 2 reported Resident 1's feeding tube was pulled out. RN 2 stated she and RN 1 went to assess Resident 1 and found the feeding tube hanging on the pole. RN 2 stated RN 1 asked her to re-confirm the placement of the feeding tube. RN 2 stated she checked the feeding tube placement by instilling 10 to 20 ml of air, and listened with her stethoscope for gurgling sound. RN 2 stated at 5 p.m. she checked the feeding tube again for placement, instilled 60 ml of air and listened to gurgling sound. RN 2 stated she administered the resident's medications and the resident received the formula feeding for five to six hours. RN 2 stated the physician was not notified and no abdominal x-ray was done. RN 2 stated the facility has a GT policy for re-inserting the GT. RN 2 stated she was not made aware the resident's feeding tube was a jejunostomy tube.</p> <p>During an interview with Director of Nurses (DON) on March 5, 2012 at 3 p.m., the DON stated RN 2, who took the telephone report from GACH, would identify whether Resident 1 had J-tube or GT. During the interview, the GACH Operative Report was provided by the DON.</p>			

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	<p>The GACH Operation Report dated November 29, 2011, provided by the DON, indicated the operation performed included feeding jejunostomy (J-tube).</p> <p>The facility's policy and procedure titled, Gastrointestinal Tube Change and Reinsertion, dated December 2000, indicated the gastrointestinal tubes will be changed/reinserted, per physician's order.</p> <p>During an interview on April 6, 2012 at 11:50 a.m. at the GACH, Physician 1 (the surgeon who inserted the initial J-tube) stated as to his recollection the resident was readmitted from the nursing home with what looked like pneumonia and possible bile obstruction. Physician 1 stated his recollection was that the resident was very sick from this process. The resident underwent a CT scan of the abdomen which was read by a radiologist, who detected that the feeding tube had a balloon on the end of it and that the balloon was inflated to such a degree it was obstructing the bile. Physician 1 stated the radiologist thought it was probably related to the degree that the tube's balloon was inflated too great for the size of the intestine. Physician 1 stated whenever someone has a bile obstruction it can make them vomit, and it is possible the vomiting led to an aspiration, which led to pneumonia. So, tie all these events together and typically the tube was the source of the problem. Physician 1 stated when the tube was put in initially; the tube did not have a balloon on it, because it</p>			

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	<p>was not that type of tube. Physician 1 stated they knew the tube had been replaced. Physician 1 stated the resident had a feeding tube that went right into the jejunum and the jejunum is small compared to the feeding tube that goes into the stomach called a gastrostomy tube. So with the GT it does not matter how much balloon is blown up because the stomach is big, but the jejunum is small. The problem was the balloon was inflated a little bit too much for the caliber of the (jejunum).</p> <p>The Los Angeles County Medical Report from the Department of the Coroner, dated January 24, 2012, indicated the immediate cause of death as intestinal obstruction due to leakage from the feeding tube.</p> <p>The Death Certificate indicated immediate cause of death as intestinal obstruction.</p> <p>The facility failed to ensure that Resident 1 received appropriate treatment and services, including but not limited to:</p> <ol style="list-style-type: none"> 1. Failure to ensure the entry site and correct type of Resident 1's feeding tube was accurately identified upon admission. 2. Reinsertion of Resident 1's feeding tube without a physician's order, in violation of the facility's policy and procedure. <p>These violations, jointly, separately or in any combination, presented either an imminent danger that death or serious harm would result</p>			

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	or a substantial probability that death or serious physical harm would result, and were a direct proximate cause of death of the patient.			

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