



CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2015
NAME OF PROVIDER OR SUPPLIER MAGNOLIA GARDENS CONVALESCENT HOSPITAL		STREET ADDRESS, CITY, STATE ZIP CODE 17822 S F Mission Blvd. Granada Hills, CA 91344-4043 LOS ANGELES COUNTY		
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	<p>practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>CFR 483.25(k) Special Needs The facility must ensure that residents receive proper treatment and care for the following special services</p> <p>CFR 483.25(k)(5) Standard: Tracheal Suctioning</p> <p>CFR 483.25(k)(6) Standard: Respiratory Care</p> <p>The Department received a complaint on March 23, 2012, alleging a resident (Resident 1) was extremely congested and struggling to breathe on January 21, 2012, and the facility's nursing staff were informed but did nothing. Resident 1 went into cardiac arrest and died two hours later. On April 2, 2012 at 2:35 p.m., an unannounced visit was made to the facility to investigate the complaint.</p> <p>The facility's staff failed to provide the necessary care and services to Resident 1, including but not limited to, failure to:</p> <ol style="list-style-type: none"> <li>1. Follow the physician's orders, including orders to suction the resident every two hours, and administer breathing treatments every four hours and as needed to maintain an open airway in accordance with the plan of care;</li> <li>2. Notify the physician when the resident was having difficulty breathing, with signs of congestion and restlessness; and</li> </ol>		<p><b>Continued From page 1</b></p> <p>The QA consultant and the medical director provided an in-service to the licensed staff regarding the respiratory distress management includes assessment, physician notification, oxygen administration, suctioning, oxygen saturation monitoring, proper nursing documentation, physician's orders and plans of care with useful interventions.</p> <p><b>Identification of Others</b></p> <p>The DON, the RN supervisor and the MDS coordinator conducted a clinical review, to ensure that no other resident will be affected by the deficient practice that has been identified in the CMS-2567.</p> <p><b>Measures to Prevent Recurrence</b></p> <p>Post the illustrated CPR instructions in the nursing stations.</p>	4/9/2015

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	<p>3. Implement the facility policy and procedure for cardiopulmonary resuscitation (CPR) and follow Resident 1's advance directive for CPR.</p> <p>These failures resulted in Resident 1's change in condition for over six hours with excessive secretions, difficulty in breathing, and restlessness. She was found unresponsive, pale in color with dilated pupils, and was pronounced dead at 10:08 p.m. on January 21, 2012.</p> <p>A review of Resident 1's Admission Record indicated the resident was a 77 year- old female, who was admitted to the facility on January 10, 2012. Her diagnoses included a right hip fracture, status-post right hip open reduction internal fixation (a surgical method of repairing a fractured bone, using plates and screws or a rod to stabilize the bone) done on January 5, 2012, leukocytosis (an elevated number of white blood cells), a gastrostomy tube (GT - a feeding tube placed directly through the skin to the stomach when a resident cannot eat or swallow safely) and Clostridium Difficile (C-diff - bacteria that cause symptoms ranging from diarrhea to life-threatening inflammation of the colon).</p> <p>There was an "Advance Directive Acknowledgment" form dated and signed January 19, 2012, by the resident's agent for health care decisions, physician, and social service designee, for a preferred intensity of care. The form indicated the resident wanted to have CPR, intravenous fluids, hospitalization, tube feeding, and no restriction of any medications or treatments.</p>		<p>Continued From page 2</p> <p>The DSD will repeat the CPR retraining program to the licensed staff every month for 3 month and then every quarterly. The DSD will provide hand-outs, demonstration and return demonstration during the in service.</p> <p>The DON will repeat the in service for the respiratory distress management every month for 3 months and then quarterly. The DON will provide hand-outs, Q&amp;A during the in service.</p> <p>The RN supervisor will monitor the residents with changes of condition on a daily basis to ensure that the physician notification and plans of care with useful interventions. The DON will conduct monthly clinical meeting to ensure the monitoring is implemented. Any findings will be corrected immediately with a follow-up in service.</p>	

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	<p>A review of a License Nurse Record dated January 10, 2012, and timed at 6 p.m., indicated upon admission the resident was non-verbal, had an indwelling urinary catheter (a flexible plastic tube used to drain urine from the bladder), was incontinent (unable to control) of bowel, was receiving feedings via a GT, and receiving antibiotics for C-diff for seven days. The breathing section documentation indicated the resident had no secretions, did not require suctioning and had a pulse oximetry (non-invasive method for monitoring oxygen in the blood) applied that read 96 percent (%) on room air (normal value is greater than 96%). According to the "Record" the resident was placed in isolation (private room) for C-diff precautions.</p> <p>The Physician's Order dated January 10, 2012, indicated the nursing staff should suction the resident's mouth every two hours and as needed with a Yankauer (a bulb tip with a large tube for maximum suction without damaging surrounding tissues) due to the pooling of secretions at the back of the resident's mouth, and give Robitussin DM liquid (cough syrup) five milliliter (ml) via GT every six hours as needed (PRN) for coughing. Another physician's order dated January 12, 2012, indicated the staff should administer the breathing treatments of Albuterol/Atrovent (bronchodilator that relaxes muscles in the airways and increases air flow to the lungs) every four hours as needed (PRN) for shortness of breath. On January 14, 2012, the physician ordered oxygen at two liters per minute by nasal cannula (N/C) as needed for labored breathing and to monitor the resident's oxygen</p>		<p>Continued From page 3</p> <p><b>Monitoring Performance</b></p> <p>The QA consultant will conduct an annual QA and the DON will conduct a quarterly QA focusing on changes of condition management with a plan of correct for the findings.</p> <p>The MDS consultant will conduct an annual QA and the MDS coordinator will conduct a quarterly QA regarding plan of care with a plan of correction for the findings.</p> <p>The DSD consultant will conduct an annual QA regarding the CPR training and the DSD will conduct a quarter QA with a plan of correction for the findings.</p> <p>The DON will present the recapitulations of the findings to the monthly QA meeting for review and action as indicated.</p>	

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	<p>saturation every shift.</p> <p>A review of the Medication Administration Record (MAR) for the month of January 2012, indicated Robitussin was not administered to the resident from January 10, 2012, through January 21, 2012. The Atrovent/Albuterol breathing treatments were administered only once on January 14, 2012, since admission January 10 through 21, 2012.</p> <p>There was no record of oxygen administration or oxygen saturation readings every shift as prescribed by the physician to assess the resident's breathing status. A review of the nurse's notes indicated the resident's oxygen saturation was not recorded on the following days: January 12, 13, 15, 16, 17, and 21, 2012, as directed in the physician's orders to be done every shift. On January 14, 2012, according to the Licensed Nurse Record, Resident 1's oxygen saturation was 98%. However, it was recorded as 89% on the Multidisciplinary Progress Record. The physician was notified and a chest x-ray was ordered on January 14, 2012. The results of the chest x-ray indicated the resident had slight right lower lobe atelectasis (a collapse of lung tissue affecting part or all of one lung. This condition prevents normal oxygen absorption to healthy tissues), but no infiltration (a density in the lungs that is not normal and usually refers to a focus of infection). The resident's lung sounds changed from being clear to having rales and crackles (can be associated with severe airway obstruction). On January 18, 2012, the resident's oxygen saturation dropped again to 94%.</p>		<p>Continued From page 4</p> <p><b>Please see attached documents</b></p>		

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	<p>A review of a plan of care, dated January 11, 2012, indicated the staff would provide medication and breathing treatments as ordered and notify the physician of signs and symptoms of congestion, shortness of breath, and labored breathing. There was no documented evidence the resident's physician was notified of the resident's change of conditions on January 21, 2012, when the resident was having difficulty breathing.</p> <p>A review of the facility's undated policy titled, "Oral-Nasal Suctioning" indicated when a resident cannot voluntarily expectorate (to cough up and spit out) to prevent aspiration of secretions, the resident should be suctioned from the mouth.</p> <p>On April 2, 2012, at 2: 30 p.m., during an interview, the director of nurses (DON) stated she remembered Resident 1 very well, because she admitted the resident on January 10, 2012. The DON stated on admission the resident had a productive cough, so cough medication and breathing treatments were ordered. However, a review of a Licensed Nurse Record, with an assessment done upon admission, dated January 10, 2012, indicated the resident's lung sounds were clear and had no secretions, and did not require suctioning.</p> <p>On April 2, 2012, at 3:10 p.m., during an interview, licensed vocational nurse 1 (LVN 1) stated that Resident 1 was awake, alert, and non-verbal, but responded to tactile (touching) stimuli, upon admission. LVN 1 stated there was pooling of</p>		<p>Continued From page 5</p> <p><b>Please see attached documents</b></p>	

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	<p>secretions at the back of the resident's mouth, which required suctioning every two hours or more. LVN 1 indicated the resident was congested and required breathing treatments and cough medicines frequently. She stated the certified nursing assistant (CNA 1) called her into the resident's room on January 21, 2012, at 9:45 p.m., to check the resident because she looked pale. LVN 1 stated she found the resident unresponsive and attempted to check her vital signs, but there was no pulse (heartbeat) or blood pressure (the pumping action of the heart). LVN 1 stated she called the registered nurse supervisor (RN 1) into the room and RN 1 re-assessed the resident at 9:47 p.m., but there was no pulse.</p> <p>When LVN 1 was asked about CPR being performed, she stated neither she nor RN 1 suctioned the resident. LVN 1 stated, "We did something, but I cannot remember if we gave her oxygen or did CPR." LVN 1 could not provide written documentation of CPR being performed on Resident 1 upon the initial assessment by LVN 1 or RN 1, or while waiting for the paramedics to arrive.</p> <p>On April 2, 2012, at 4 p.m., during a telephone interview, RN 1 stated that sometime after 7 p.m., on January 21, 2012, CNA 1 reported to LVN 1 that Resident 1 "was gone." LVN 1 went into the room and observed that the resident was cyanotic (bluish discoloration of the skin and mucous membranes due to not enough oxygen in the blood) and cool to touch. LVN 1 called a Code Blue (a medical emergency in which a team of medical personnel work to revive an individual whose heart has</p>		<p>Continued From page 6</p> <p><b>Please see attached documents</b></p>	

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	<p>stopped) and all the staff rushed into the room. LVN 1 checked the resident's vital signs, but the resident had no pulse or blood pressure. RN 1 stated she was not sure if the resident was a Full Code (to be resuscitated in the event of a cardiac or respiratory arrest) or not at the time of the incident. She stated, "I started light chest compression without opening the resident's airway by using two fingers to compress the resident's chest while the resident was in bed." [According to the American Heart Association (AHA), a two- hand procedure should be used to press hard on the resident's center chest, by placing the heel of one hand over the center of the chest and place the other hand on top and interlace your fingers]. When RN 1 was questioned about the accurate procedure to perform chest compression she stated, "Cardiac compression can be done in two ways either by using a cardiac board or placing the resident on the floor." However, according to RN 1, she did not use either method, or follow the AHA CPR guidelines. RN 1 stated she did not use an Ambu Bag (a resuscitator bag used to maintain ventilation) on the resident. She stated she did not suction the resident in an attempt to open the resident's airway, or turn the oxygen on.</p> <p>On August 6, 2012, at 6:10 p.m., during an interview, CNA 2 stated that on January 21, 2012, the resident was having difficulty breathing and became very restless. CNA 2 stated LVN 1 suctioned the resident at 3 p.m., but the resident was very agitated and did not want to lie down in bed, because she could not breathe while in a lying position. CNA 2 stated the resident wanted to</p>		<p>Continued From page 7</p> <p><b>Please see attached documents</b></p>	
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	<p>either sit up or stand up (orthopneic - a body position that enables a person to breathe easier).</p> <p>According to the National Institutes of Health (NIH), acute upper airway obstruction is a blockage of the airway, which can be in the trachea (a tube that connects the nose and mouth to the lungs), laryngeal (voice box), pharyngeal (throat) areas, which can be caused by foreign bodies; and common symptoms to all types of airway blockage include agitation or fidgeting, difficulty breathing, gasping for air, and cyanosis (a bluish color to the skin). According to the American Heart Association (AHA), 2005 edition, Adult Basic Life Support, CPR is an emergency medical procedure for cardiac arrest; consisting of artificial blood circulation and artificial respiration (chest compression and lung ventilation). AHA indicates CPR must be started at once when a person is in cardiac arrest and placed on a hard, flat surface.</p> <p>A review of a Multidisciplinary Progress Record, dated January 21, 2012, and timed at 8 p.m., indicated the resident's family was at the bedside and the resident had no shortness of breath or distress noted. The note also indicated the resident was suctioned. However, on February 10, 2012, at 10:20 a.m., during a telephone interview and a review of a written declaration, the resident's family care giver, stated she did visit the resident the evening of January 21, 2012. She stated once she arrived at the facility she found the resident in bed without pajamas and had to clean her up and put pajamas on the resident. She stated the resident had a lot of secretions around her eyes and mouth</p>		<p>Continued From page 8</p> <p><b>Please see attached documents</b></p>		

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	<p>and she cleaned those areas. She stated the resident had a hard time breathing with fast labored breaths. She stated she notified the nurses and they stated the resident receives breathing treatments and they would come in and check on her, but they did not come, so she went to remind them. She stated they promised they would go and check on her while she left the facility. The family care giver stated she left the facility after being reassured they would check on the resident and as soon as she got home, within two hours, the facility called her and stated the resident had a cardiac arrest and died.</p> <p>A review of the facility's undated policy titled "CPR" indicated the staff would provide life support to an individual who needs to be resuscitated. The policy also indicated once CPR is initiated, it shall be continued until effective circulation and breathing are restored in the resident and or if the resident is transferred to the care of emergency medical services. A review of Resident 1's Advance Directive dated and signed January 19, 2012, indicated CPR was selected as a preferred intensity of care authorized by the resident.</p> <p>A review of the Multidisciplinary Progress Record, dated January 21, 2012, and timed at 9:45 p.m., indicated the resident had no pulse or blood pressure.</p> <p>According to the Licensed Nurse Note dated January 21, 2012, at 9:55 p.m., RN 1 called 911, and at 10 p.m., the paramedics arrived and pronounced the resident dead at 10:08 p.m.</p>		<p>Continued From page 9</p> <p><b>Please see attached documents</b></p>		
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	<p>According to the Multidisciplinary Progress Record, dated January 21, 2012, the paramedics arrived at 10 p.m., and at 10:08 p.m., they pronounced the resident dead. At 10:18 p.m., the family was notified of the resident's death. At 10:29 p.m., two police officers arrived at the facility and the physician was notified of the resident's death.</p> <p>The facility's staff failed to provide the necessary care and services to Resident 1, including but not limited to, failure to:</p> <ol style="list-style-type: none"> <li>1. Follow the physician's orders, including orders to suction the resident every two hours, and administer breathing treatments every four hours and as needed to maintain an open airway in accordance with the plan of care;</li> <li>2. Notify the physician when the resident was having difficulty breathing, with signs of congestion and restlessness; and</li> <li>3. Implement the facility policy and procedure for cardiopulmonary resuscitation (CPR) and follow Resident 1's advance directive for CPR.</li> </ol> <p>The above violations either jointly, separately, or in any combination presented either an 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 death of Resident 1.</p>		<p>Continued From page 10</p> <p><b>Please see attached documents</b></p>	

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