

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555623	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2008
NAME OF PROVIDER OR SUPPLIER HEMET VALLEY HEALTHCARE CENTER D/P SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 371 NORTH WESTON AVENUE, HEMET, CA 92543 RIVERSIDE COUNTY		
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	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit.</p> <p>Representing the Department of Public Health: [REDACTED], HFEN</p> <p>CLASS AA CITATION -- PATIENT CARE 25-2078-0005326-S Complaint(s): CA00137056, CA00147450</p> <p>Nursing Service-General 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. (B) Development of an individual, written patient care plan which indicates the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited. (3) Notifying the attending physician promptly of: (B) Any sudden and/or marked adverse change in signs, symptoms or behavior exhibited by a patient.</p> <p>72523 Patient Care Policies and Procedures (a) Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved.</p>			

Event ID: JY2Q11

8/28/2008

10:53:25AM

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	<p>Continued From page 1</p> <p>During a complaint investigation initiated on January 9, 2008, it was determined the facility failed to ensure that nursing services included the identifying and planning of Patient A's care, which included a continuing assessment of the patient's care needs, developing an individualized written care plan, consistently and promptly notifying the attending physician of any sudden and/or marked adverse changes in signs or symptoms exhibited by Patient A. The facility also failed to implement the facility's policy and procedure for assessing Patient A's head injury.</p> <p>Review of Patient A's medical record revealed an 81-year-old female, admitted to the facility on September 13, 2007, with the following diagnoses:</p> <ol style="list-style-type: none"> 1. Pulmonary embolus; 2. Deep vein thrombosis; 3. Weakness; and 4. Colitis. <p>Patient A was admitted for short-term rehabilitation therapy. Her goal was to be discharged home with her son. Patient A had a fair response to therapy after two days of therapy. Review of the facility's form, "Inpatient Monthly Rehabilitation Record" dated September 14, 2007, indicated Patient A required extensive assist for functional mobility, gait training (Patient A was able to stand only), moderate assist for bed mobility and transfers from bed to wheelchair. She required maximum assist for gait/wheelchair mobility.</p>				

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	<p>Continued From page 2</p> <p>The Minimum Data Set (MDS) was not completed, due to the short duration of stay. The "Nursing Admission Assessment", dated September 13, 2007, indicated Patient A was alert and oriented to person, place and time. The undated facility form, "Activities of Daily Living Profile", indicated that Patient A was able to communicate her needs. This form indicated Patient A required extensive assist in bathing, toileting, dressing, personal hygiene, transfers, positioning, and locomotion.</p> <p>The admission orders for Patient A, dated September 13, 2007, included Coumadin 4 mg daily and Lovenox 55mg subcutaneous injection every 12 hours for 5 days (both are blood thinners).The use of either one of these medications increases the risk of bleeding to any person if they bump themselves or sustain an injury, per the "Physician's Desk Reference" (PDR).</p> <p>The "Physical Therapy Progress Notes" had a late entry dated September 17, 2007, documented by the Physical Therapist (PT), in which the PT documented that on September 14, 2007, around 2:30 p.m., he assisted Patient A to sit on the edge of her bed. Patient A had "fair" balance. When the therapist bent down to get Patient A's slippers, she leaned backwards and hit her head on the side rail.</p> <p>On January 2, 2008, at 3:45 p.m., the PT was interviewed. The PT stated he did not report the injury to the nursing staff. The PT stated he would report an injury to the nursing staff if it were serious, or if he would have seen a subtle change in the patient, which would be a change in vital signs</p>				

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	<p>Continued From page 3</p> <p>or mentation. The PT assessed Patient A's mentation and he did not notice any change, and Patient A did not complain of a headache or blurred vision. The PT stated it was his decision not to notify the nursing staff about Patient A's head injury. He was aware that the patient was receiving Coumadin and Lovenox. There was no documentation to reflect the vital signs or the assessment of Patient A's mentation by the PT.</p> <p>The Licensed Vocational Nurse (LVN 1) documented, on September 14, 2007, at 6:25 p.m., that Patient A's son reported Patient A had received rehabilitation earlier in the day and leaned back and "hit her head on a chair." LVN 1 conducted a body assessment which consisted of palpating the back of her head for a bump, redness or swelling. LVN 1 documented there was "frequent head monitoring in progress." The facility's policy titled, "Change in Resident's Condition Assessment Guidelines" indicated the following:</p> <p>Neuro-lethargy-Head trauma</p> <ol style="list-style-type: none"> 1. Check vital signs, 2. Lethargic, comatose. 3. Eyes: PERL (pupils equal and reactive to light); ask if change in vision. 4. Grips equal, bi-lateral equal. 5. Following change of condition involving head injury, neurological checks are to be performed as follows: <ol style="list-style-type: none"> a. Every fifteen minutes times one hour b. Every one hour time four hours 				

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	<p>Continued From page 4</p> <p>c. Every four hours times four.</p> <p>There was no documentation to reflect that neurological assessments (neuro checks) were performed, which would include; upper extremity grasps, vital signs, the mentation (if the patient was alert or confused), the pupil size of each eye, if the patient was lethargic or if there were complaints of a headache.</p> <p>On January 31, 2008, at 2:20 p.m., LVN 1 was interviewed. LVN 1 stated the son of Patient A reported the head injury on September 14, 2007, approximately 6 or 6:30 p.m. LVN 1 stated he assessed Patient A for injuries. He checked her head for bumps but did not perform neuro checks. He stated it is routine to do neuro checks after a head injury, but they were not done per facility's policy and procedure. Further interview with LVN 1 revealed that on September 14, 2007, LVN 1 notified Registered Nurse (RN 1) of Patient A's head injury. At the end of the shift, at approximately 11 p.m., when LVN 1 was completing his documentation, he questioned RN 1 if she had notified the physician. RN 1 answered affirmatively and stated she had notified the physician, and there were no new orders.</p> <p>On January 9, 2008, at 9:10 a.m., Patient A's son was interviewed. The son stated after his mother had told him about the incident on September 14, 2007, he went to the nursing station to find if the staff were aware of the injury. The son was told that they were not aware. The son also stated he found later that the facility did not notify the</p>				

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	<p>Continued From page 5</p> <p>physician of the incident.</p> <p>The nurse's notes revealed RN 1 was made aware of the head injury. There was no documentation to reflect that Patient A was assessed by RN 1.</p> <p>A review of the personnel file for RN 1 revealed that she was terminated from employment at the facility on September 27, 2007. The reason for termination was failure to assess Patient A and failure to notify the physician following the head injury. The personnel file also included a letter with an investigative statement written by the Nurse Manager (NM) on September 17, 2007. The statement indicated that RN 1 told the NM she did not notify the physician because she did not think Patient A's head injury was "anything big."</p> <p>RN 1 failed to conduct an assessment of Patient A, and failed to notify the physician that Patient A sustained a head injury, on September 14, 2007.</p> <p>On September 15, 2007, at 2 p.m. (23 hours after Patient A injured her head, the licensed nurse's notes indicated Patient A's blood pressure was 85/57 millimeters of Mercury (mmHg). The normal range of a blood pressure would be 120-140/60-90 mmHg. Patient A was "put on Trendelenberg" by the licensed nurse. In this position, the foot of the bed is raised and the head is lower than the feet. This position is used in the case of shock or low blood pressure, per "Taber's Cyclopedic Medical Dictionary."</p> <p>There was no documented evidence that the</p>			

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	<p>Continued From page 6</p> <p>physician was notified that Patient A had sustained a head injury, or the recent documented decrease in blood pressure.</p> <p>On September 15, 2007, at 11:05 p.m., the licensed nurse's notes indicated that Patient A's blood pressure was 86/60 mmHg and the pulse was 91. The normal pulse range would be 78-82 per minute in women, per "Taber's Cyclopedic Medical Dictionary." There was no documentation that the physician was informed of the decrease in blood pressure or the increase in pulse.</p> <p>On September 16, 2007, at 12:30 a.m., (34 hours after the head injury) the nurse's notes indicated Patient A was unable to be awakened and was non responsive to verbal and tactile stimuli. The physician and 911 were contacted. At 12:42 a.m., Patient A was transported to a general acute care hospital (GACH).</p> <p>Review of Patient A's medical record at the GACH, revealed that a brain CT scan was performed in the Emergency Room. The results were, "a mixed, acute and chronic right subdural hematoma, measuring 3.7 centimeters in thickness, extending along the right frontal, parietal, temporal and occipital lobes." Patient A was intubated and put on life support. The diagnoses included acute subdural bleed and respiratory failure.</p> <p>On September 16, 2007, at 4:30 a.m., Patient A was transferred to another GACH via Critical Care Transport, due to the need for higher level of care and neurosurgery.</p>			

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	<p>Continued From page 7</p> <p>Patient A arrived at that hospital at 6:35 a.m., and still remained unresponsive to pain and verbal stimuli. She remained on life support until 3 p.m., when the family decided to withdraw life support. Patient A was pronounced dead, at 3:45 p.m., on September 16, 2007.</p> <p>Review of the death certificate for Patient A, revealed that the cause of death was due to:</p> <ol style="list-style-type: none"> 1. Intracerebral hemorrhage 2. Pulmonary embolism etiology unknown. <p>Record review and interview with the Director of Nurses (DON), on January 9, 2008, at 2:15 p.m., revealed that the PT did not notify the nursing staff of the head injury.</p> <p>Record review and interview with the Nurse Manager (NM), on January 31, 2008, at 1:40 p.m., revealed RN 1 did not assess Patient A after learning of her head injury, nor did RN 1 notify the physician of the incident.</p> <p>The facility failed to ensure that nursing services included the planning of Patient A's care, which included the continuing assessment of the patient's neurological status and the mentation and vital signs after the head injury, per the facility's policy and procedure. There was no documentation to reflect the facility's nursing staff had assessed the reason for Patient A's decrease in blood pressure or increase in pulse, on September 15, 2007.</p>				

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	<p>Continued From page 8</p> <p>The facility staff failed to promptly notify Patient A's attending physician of the patient's head injury and the change in vital signs.</p> <p>The facility's failure to notify the attending physician of the head injury resulted in a delay of diagnostic studies and treatment. The CT scan could have been performed earlier and the possibility of intervention by a neurosurgeon to decrease the progression of the intracranial bleed could have improved the outcome.</p> <p>The facility's failure to assess Patient A's neurological status, follow their policy and procedure to perform neuro checks, and assess the change in vital signs from September 14 and 15, 2007, caused a significant delay in the identification of Patient A's intracerebral hemorrhage (bleeding).</p> <p>The facility's failure to properly assess the neurological status by performing neuro checks resulted in failure to detect the intracerebral hemorrhage in time to successfully intervene.</p> <p>The facility's failure to notify the physician about Patient A's head injury with the use of anticoagulant therapy and the two hypotensive (low blood pressure) episodes further delayed the identification and treatment of the hemorrhage.</p> <p>The use of anticoagulant therapy with a head injury increases the risk of intracranial hemorrhage. Patient A received two anticoagulant medications. The facility failed to notify the physician so the physician did not have the opportunity to reverse</p>				

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	<p>Continued From page 9</p> <p>the anti-coagulant treatment.</p> <p>These violations presented either an imminent danger to Patient A that death or serious harm would result and were a direct proximate cause of the death of the patient.</p>			
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