

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555226	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2008
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NAME OF PROVIDER OR SUPPLIER THE SPRINGS AT THE CARLOTTA	STREET ADDRESS, CITY, STATE, ZIP CODE 41-505 CARLOTTA DRIVE, PALM DESERT, CA 92211 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 25-1437-0004805-S Complaint(s): CA00092190</p> <p>A Plan of Correction Visit was conducted, on April 03, 2008, and the facility was found out of Compliance with their plan of correction.</p> <p>72311. Nursing Service - General (a) (1) (A) (a) Nursing services 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>On September 27 and November 3, 2006, unannounced visits were made to the facility for the purpose of investigating a complaint. It was determined the facility failed to continually assess Patient A's nursing needs, which resulted in Patient A's death. The following was noted:</p> <p>Patient A, a female 87 years of age, was admitted</p>			
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1:29:35PM

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	<p>Continued From page 1</p> <p>to the facility on June 5, 2006, with diagnoses including fractured pelvis after a fall, constipation, and hypertension.</p> <p>On June 29, 2006, Patient A complained to facility staff that she was constipated and unable to have a bowel movement. The facility licensed nurse noted Patient A had no bowel sounds and her abdomen was firm and distended. The physician was notified and ordered Patient A to be transferred to the acute hospital.</p> <p>Patient A was seen in the emergency room on June 29, 2006. Patient A was taken for a CT scan of the abdomen. During the scan Patient A expired.</p> <p>On September 27, 2006, Patient A's health record was reviewed at the facility. The Minimum Data Set (MDS) Assessment with a reference date of June 5, 2006, indicated Patient A's bowel elimination pattern included constipation.</p> <p>On admission to the facility, the physician ordered Psyllium (fiber to assist with bowel regularity) to be administered every day in twelve ounces of water. On June 9, 2006, Licensed Vocational Nurse 1 (LVN 1) documented in the nursing progress notes that Patient A complained of not having a bowel movement for multiple days. LVN 1 documented the Psyllium was not effective. On June 9, 2006, LVN 1 further documented she notified the physician. Per Physician orders on June 10, 2006, and nursing documentation, Patient A received Milk of Magnesia 20 cc every night from June 11 through</p>			
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	<p>Continued From page 2</p> <p>June 28, 2006. Patient A also continued to receive the Psyllium.</p> <p>On June 5, 2006, a nursing care plan was initiated, listing "Potential for Constipation" as one of the identified problems. The interventions included monitoring and recording of bowel movements, with a goal that Patient A would have at least one bowel movement every three days.</p> <p>A review of documents in the facility on September 27, 2006, showed that the monitoring and recording of bowel movements (BM) for patients, was documented on: (1) the facility daily BM list, (2) the nurse's aides notes in the health record, (3) the weekly summary in the health record, and, (4) the Nursing Progress Notes in the health record. A summary of the monitoring of bowel movements for Patient A was as follows:</p> <p>* The first documented bowel movement was on June 13, 2006, eight days after admission to the facility</p> <p>* There was a small bowel movement documented on the daily BM list on the day shift for June 13, 2006. The Nurse's Aide Notes for the same day and shift had documentation indicating no BM occurred. There was no documentation of a BM on the Nursing Progress Notes for the same day.</p> <p>* According to the daily BM list, there was documentation that Patient A had two large BM's on the day shift for June 24, 2006. The Nurse's Aide Notes for the same date and shift had documentation indicating no BM occurred. The</p>			
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	<p>Continued From page 3</p> <p>daily BM list indicated that Patient A had a medium BM on the night shift on June 24, 2006. The Nurse's Aide Notes for the same date and shift had documentation that no BM occurred. There was no documentation of a BM on the Nursing Progress Notes for the same day.</p> <p>* The daily BM list indicated that Patient A had a small BM on the evening shift on June 26, 2006. The Nurse's Aide Notes for the same date and shift are blank.</p> <p>* An entry on the Nursing Progress Notes dated June 29, 2006, indicated that the last BM Patient A had was on June 26, 2006. There was no documentation in the health record that Patient A had a BM on that date.</p> <p>During the review of the forms, it was noted that information on one form conflicted with information on another form, which made it difficult to ascertain if Patient A had a BM on a particular day or shift.</p> <p>Certified Nursing Assistant 1 (CNA 1) was interviewed at 12:30 PM, on September 27, 2006. CNA 1 stated it was her practice and the standard practice of the facility to monitor bowel movements on every patient every shift. CNA 1 further stated that if a patient she was caring for did not have a bowel movement during her shift, she reported it to the nurse responsible for that patient. There was no evidence in Patient A's health record that any CNA notified a nurse of Patient A's failure to have a bowel movement until June 29, 2006.</p>			

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	<p>Continued From page 4</p> <p>LVN 2 was interviewed at 12:35 PM, on September 27, 2006. LVN 2 stated the nursing staff monitored bowel movements on the patients by referring to the BM (Daily BM list) clipboard, located in a central location at the nurse's station, and stored in medical records by date. LVN 2 further stated that the practice at the facility was to monitor bowel movements, and if a patient has not had a bowel movement for 2 to 3 days, they will "usually" get a stool softener. LVN 2 stated, "Most of our patients are on stool softeners anyway."</p> <p>On November 3, 2006, at 2 p.m., an interview was held with LVN 3. LVN 3 stated the facility's bowel program was "that after three days, if no BM, the nurse is to call the physician and check the doctor orders for an order for Milk of Magnesia. On the fourth day, if still no BM, the nurse is to check digitally for a fecal impaction."</p> <p>On June 22, 2006, LVN 1 documented on the nursing progress notes that Patient A was, "noted attempting to vomit." LVN 1 further documented Patient A, "attempts to gag herself." On June 23, 2006, at 12:30 p.m., LVN 1 documented Patient A had complained of nausea and vomiting at 8 a.m. that morning, and again at 1 p.m., after lunch.</p> <p>On June 29, 2006, CNA 2 documented on the nurse's aide notes Patient A was "very constipated," and unable to have a bowel movement. CNA 2 further documented, "Nurse gave her an enema."</p>			
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	<p>Continued From page 5</p> <p>On June 29, 2006, at 11 a.m., the nursing progress notes indicated Patient A refused her breakfast, her abdomen was distended, and she had begun to vomit. LVN 1 documented in the notes there was no existing bowel regimen, so she contacted the physician and received orders for a Fleets enema, Colace (a stool softener), Milk of Magnesia (which Patient A was already receiving nightly), and a Dulcolax suppository. Further documentation in the nurse's notes indicated LVN 1 administered the enema at 11 a.m., and the nurse was awaiting results.</p> <p>There was no further documentation found in the nurses progress notes until 7:50 p.m., on June 29, 2006, when LVN 1 documented, "Received notice that the patient was to be transferred to an acute care hospital to rule out a Bowel Obstruction." LVN 1 noted at that time, that Patient A had no bowel sounds, and her abdomen was firm and distended. There was no documentation recorded of any results from the enema.</p> <p>On November 3, 2006, at 2 p.m., an interview was held with LVN 3. When asked how long she would wait for results of a Fleets enema after administration, LVN 3 stated, "You should see enema results in one hour. If not, you need to call the physician."</p> <p>The acute care hospital emergency room (ER) physician documented on June 29, 2006, that on arrival to the emergency room, Patient A was minimally responsive and her abdomen was distended. The ER physician documented that</p>			
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	<p>Continued From page 6</p> <p>laboratory studies and x-rays were ordered and an intravenous line was started, but, while awaiting the studies, Patient A had an abrupt change in her mental status and her blood pressure dropped. It was documented by the ER physician that Patient A was, "rushed to the CT scanner where as my concern was for perforated viscus (organ of the digestive tract) versus a ruptured AAA (abdominal aortic aneurysm). Unfortunately, the patient expired on the CT table." The ER physician documented that Patient A had a "cardiac arrest from what appears to be a perforated viscus given free air on the abdominal CT."</p> <p>An "Autopsy Protocol" report signed August 2, 2006, by the Forensic Pathologist documented Patient A's cause of death as, "Acute Peritonitis due to perforated colon due to severe constipation."</p> <p>A signed certificate of death dated August 18, 2006, listed Patient A's cause of death as: A. Acute Peritonitis B. Perforated Colon C. Severe Constipation-Etiology Unknown.</p> <p>The facility's failure to identify the care needs of Patient A based on an initial and continuing assessments and to correctly monitor Patient A's bowel elimination pattern, resulted in Patient A developing nausea, vomiting, an inability to eat, abdominal pain and distension from June 22, 2006, until she expired on June 29, 2006.</p> <p>Prior to admission to the facility, Patient A lived alone in her own home. A paid caregiver came into</p>			
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	<p>Continued From page 7</p> <p>Patient A's home during the day to assist with personal care. During a telephone interview with Patient A's family member on March 5, 2007, at 2:15 p.m., the family member stated the plan for Patient A was that once she recovered sufficiently to function at her prior level, Patient A would return home with the paid caregiver as before.</p> <p>The facility's failure to identify the care needs of Patient A based on an initial and continuing assessment of Patient A, presented an imminent danger to Patient A and was a direct proximate cause of the death of Patient A.</p>			
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