accepted 5/4/16

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California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000191	A. BUILDING: _____ B. WING _____	C 01/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE MEMORIAL MEDICAL CENTER	1720 E CESAR AVENUE LOS ANGELES, CA 90033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	Initial Comments The following reflects the findings of the Department of Public Health during an investigation of a complaint and an entity reported incident: Intake Numbers: CA00341956 and CA00348213 Representing the Department of Public Health: Evaluator ID #25524, RN, HFEN The inspection was limited to the specific complaint and facility reported event investigation and does not represent the findings of a full inspection of the facility. 1280.3(g) Health and Safety Code Section 1280 For purposes of this section, "Immediate Jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or likely to cause, serious injury or death to the patient.	E 000		
E 264	T22 DIV5 CH1 ART3-70213(a) Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. This Statute is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement its policy and procedure on assessment, preventions and management of pressure ulcers, including but not limited to failures to:	E 264	All items listed in E 264 have been corrected as listed below and no other patients were impacted by these deficiencies: The Process for Pressure Ulcer or Skin/Wound Abnormalities documentation was revised due to the root cause analysis conducted from this event (Attachment A-Pressure Ulcers, Wound and Skin Abnormalities Photo Documentation Form)	Form revision completion 06/30/2013

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maria C Bryant — TITLE: Senior Vice President — (X6) DATE: 4/26/2016

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E 264	Continued From page 1 1. Complete a "Skin Risk" assessment using the Braden Scale (tool used to assess a patient's risk of developing pressure ulcer [an inflammation, sore, or ulcer in the skin over a bony prominence]) for Patient 1 while in the emergency department. 2. Complete an initial assessment of the patient's skin while in the emergency department for signs of potential skin breakdown and document on the "Initial Skin Assessment" form. 3. Change the patient's position, while in bed, to the right, left or supine position, every two hours, while in emergency department between January 5, 2013 at 7:15 a.m. and January 6, 2013 at 1 p.m. and to change the patient's position to the right, left, or supine position, every 2 hours, after 12 p.m. on January 7, 2013. 4. Evaluate Patient 1 for pressure-redistribution bed surface, prior to development of sacral pressure ulcer (a pressure ulcer that forms on the upper buttocks). Patient 1 was admitted to the facility on January 5, 2013, with no pressure ulcer and developed a pressure ulcer on the sacral area on January 7, 2013 measuring 15 centimeters (cm) by 13 cm. Patient 1 underwent an excision and debridement procedures of the sacral pressure ulcer, Stage III, under local anesthesia on two occasions, January 27, 2013 and on February 22, 2013. Patient 1 underwent debridement of the sacral pressure ulcer and application of wound VAC device under general endotracheal anesthesia in the operating room on March 8, 2013.	E 264	Reeducation on the policy and Competency was completed for Emergency Department Staff (Attachment: Policy B-a and Sample competency B-b). The policy includes the following components: 1. Skin risk assessment process for patients who are admitted and waiting in the Emergency Room includes: a. A head to toe initial skin assessment will be completed by the primary nurse and identification of pressure ulcers, skin abnormalities and wounds will be documented on designated forms. b. Patients will be repositioned every 2 hours, unless contraindicated and all bony prominences assessed at that time 2. Initial assessment and ongoing assessment for inpatients (including admitted patients waiting in ED for room assignment): a. A head to toe skin assessment is completed with initial assessment of the patient. b. For patients at risk of developing a pressure ulcer and awaiting inpatient bed assignment, the patient will be moved from the standard emergency department gurney and placed on a standard hospital bed within 4 hours. The picture of skin abnormalities are	

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E 264	Continued From page 2 Findings: On January 9, 2014, an unannounced visit was conducted at the facility to investigate a complaint regarding allegation that the patient was admitted to the hospital and developed a wound that covered the middle of the patient's buttocks. On January 9, 2014, a review of Patient 1's electronic medical record was conducted. Patient 1's Registration Record indicated the patient, a 73 year old, was brought to the general acute care hospital's emergency department (ED) on January 5, 2013, at 8:57 a.m. with diagnosis of urosepsis (serious infection which occurs when an infection in the urinary tract spreads to bloodstream). The History and Physical dated January 5, 2013, at 10:08 a.m., indicated the physician's impression included encephalopathy (abnormal brain function manifested by altered mental status) likely due to sepsis (serious infection), non-insulin dependent diabetes mellitus and altered mental status. The physical examination revealed the patient was awake, verbally non responsive and the skin was intact, warm, and moist. The plan was to admit the patient to the Direct Observation Unit (DOU). The ED Triage and Initial assignment, dated January 5, 2013 at 7:15 a.m., indicated the patient's skin was described as normal and dry. On the Nursing Documentation - Flowsheet, Patient's skin was assessed as normal and the skin was reassessed again as "normal" and "no change from the previous assessment" at 4:10 p.m., 9:00 p.m., 11:00 p.m. and on January 6, 2013 at 5:24 a.m., and at 8:00 a.m.	E 264	now documented in the electronic record. Additionally, each newly hired employee receives training on the Pressure Ulcer interventions and documentation during new employee orientation (Attachment C- New employee orientation material) The audit to monitor compliance on complete skin assessment, repositioning patients every two hours and timely assigning of the hospital beds to inpatients waiting in the ER will be monitored for the next three months. The Chair of the Wound care task force will be responsible for overall compliance. The data will be reported to the Patient Safety Committee.	start date 04/27/2016 Ongoing for next three months

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E 264	Continued From page 3 The Nursing Documentation-Flowsheet dated January 6, 2013, indicated the patient's skin was warm, dry, and intact at 11:00 a.m. and at 1 p.m., there was no change from previous assessment. The Emergency Department Reports under "Location of Information" indicated the patient was in the emergency department from 7:10 a.m. on January 5, 2013 and was transferred to 5 North, (Direct Observation Unit) at 6:28 p.m. on January 6, 2013. This indicated the patient was in the ED for 35 hours and 17 minutes. While Patient 1 was in the emergency department, there was no documentation that a "Skin Risk" assessment using Braden Scale (tool used to assess a patient's risk of developing pressure ulcer) was completed for Patient 1. There was no documentation in the emergency department that an initial assessment of the patient's skin, especially pressure points, skin folds, perineal area (area between the genital and the anus) for signs of potential skin breakdown and any skin abnormalities, was completed and documented on the "Initial Skin Assessment" form. There was no documented evidence provided that the patient was repositioned in bed every two hours. The ED Department notes dated January 6, 2013 at 5:49 p.m., indicated Patient 1 was transported to the Direct Observation Unit (DOU). The patient was lethargic and was on oxygen therapy and a cardiac monitor. The Emergency Department Reports under "Location of Information" indicated the patient was transferred to 5 North, (Direct Observation Unit) at 6:28 p.m. on January 6, 2013. A review of the Initial Skin Assessment, dated January 6, 2013 (no time), conducted by a	E 264		

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E 264	Continued From page 4 licensed nurse and verified by a charge nurse indicated Patient 1's skin was "intact" and there was no documentation the patient was assessed for any skin abnormalities. A review of the Order (Patient Care) dated January 6, 2013 at 7:38 p.m. indicated a nursing order for Braden scale. Patient 1's Braden scale was assessed as "At risk/Moderate risk." Another nursing order dated January 6, 2013 at 7:38 p.m., indicated "Turn patient Q (every) 2 hours." A review of the Nursing Documentation/ADLs dated January 6, 2013 at 8 p.m., indicated Patient 1's position was changed to supine (body lying face up). A review of the Nursing Documentation-Flowsheet dated January 6, 2014, indicated the patient's position was changed to the left side at 10 p.m., to supine at 12:00 a.m. on January 7, 2013, to the right on at 2:00 a.m., to the left at 4:00 a.m., and to the left at 6:00 a.m. On January 7, 2013 at 7:05 a.m., the Braden scale score for Patient 1 was "16" which identified Patient 1 was at risk for skin breakdown (score between 15 and 18 identifies the patient is at risk). There was no documented evidence found in the Nursing Documentation-Flowsheet that the patient's position was changed to the right, left, or supine position, every 2 hours, after 12 p.m. on January 7, 2013, and that all bony prominences for potential skin breakdown were assessed. The next documentation that the patient was repositioned was on January 8, 2013 at 6 a.m. According to the Nursing Documentation Flowsheet dated January 7, 2013, at 8:00 p.m., Patient 1's Braden scale score was "14" which identified the patient as moderate risk for developing pressure ulcer. Patient 1 was	E 264		

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E 264	Continued From page 5 identified with a hospital acquired pressure ulcer on the right and left buttocks, coccyx (tailbone) and sacral (area where upper buttocks meet the lower back) area. The hospital acquired pressure ulcer was described as having blisters, Stage 1, and "suspected deep tissue injury." According to the Ongoing Pressure Ulcer Photo Documentation dated January 7, 2013, taken on the Direct Observation Unit, indicated a deep tissue injury, Stage II on the sacrum/coccyx-bilateral buttocks, measuring 15 centimeters (cm) by 13 cm, with broken blister. There was a lump with skin tear on the upper back, measuring 0.5 cm by 0.5 cm, excoriation (any surface injury to the skin; may be caused by scratches, chemical or thermal burns, and abrasions) on the scrotum, measuring 1 cm by 0.5 cm. An electronic record review for Patient 1 on January 9, 2014, at 12 p.m., was conducted with Registered Nurse (RN) 1, lead nurse educator. During a concurrent interview, RN 1 stated that on January 5, 2013, there was no skin risk assessment using Braden scale completed by the licensed nurse in the emergency department overflow area. RN 1 stated a skin risk assessment was supposed to be done upon admission and every 12 hours. RN 1 stated there was no documentation that the patient was evaluated for a pressure-redistribution bed. RN 1 stated there was no documentation that the patient was repositioned every two hours after 12 p.m. on January 7, 2013. RN 1 further stated the next documentation that the patient was repositioned was on January 8, 2013 at 6 a.m. According to the facility's policy and procedure on Pressure Ulcer or Skin/Wound and Conditions-Assessment, Preventions and Management with	E 264		

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E 264	Continued From page 6 a start date February 1, 2010 and an approved date October 24, 2012, indicated the following: 1. A deep tissue injury is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. 2. Stage I is defined as an intact skin with non-blanchable redness of a localized area usually over a bony prominence. 3. Stage II is partial thickness loss of dermis and presenting as a shallow open ulcer or open/ruptured serum-filled blister. Bruising indicated "suspected deep tissue injury." 4. Stage III is full thickness tissue loss. Subcutaneous may be visible; bone, tendon or muscle are not exposed. 5. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Include undermining and tunneling. On January 13, 2014, at 10:45 a.m., during an interview, RN 4 (emergency department manager) stated Patient 1 presented to the emergency department, was admitted and stayed in the "ED over flow" area to wait for a bed available in an inpatient unit. A review of the Emergency Department Reports "Location Information" indicated Patient 1 was admitted to 5 North Direct Observation Unit (DOU)on January 6, 2013 at 6:28 p.m.	E 264		

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E 264	Continued From page 7 On January 13, 2014 at 10:10 a.m., during an interview, RN 5 stated RN 3 had mentioned to him that there was a birth mark on Patient 1's sacral area. On January 29, 2014, at 11:30 a.m., during a telephone interview, RN 3 (Staff RN in DOU) stated that she remembered that she assessed Patient 1's skin (did not mention a date) and it looked like there was a "keloid or birth mark" on the sacral area. RN 3 stated that it was not unusual due to the patient's dark skin. A review of Special Surface Mattress Order Form dated January 8, 2013 at 4:56 p.m., and at 5:40 p.m., indicated two orders for "Sentech mattress" (primary care low air loss and alternating pressure mattress system). During an electronic record review and interview with RN 2 on January 13, 2014, at 8:45 a.m., RN 2 stated Patient 1 received a Sentech mattress alternating pressure redistribution mattress on January 9, 2013 (2 days after identification of deep tissue injury on the patient's sacral area). A review of the Clinical Note Wound Care/Ostomy note dated January 8, 2013 at 3:19 p.m., disclosed the wound care nurse evaluation. The "sacrococcyxgeal" pressure ulcer was a Stage II, with dark skin on the site, and the lower end had an open skin showing pink skin with serosanguinous (blood and serous fluid) drainage. The "sacrococcyxgeal" pressure ulcer also had some intact blisters noted on the inside the wound bed area. The peri-wound (tissue surrounding the wound itself) was intact and with some skin denudement (excoriated skin). On January 16, 2013, the Ongoing Pressure	E 264		

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E 264	Continued From page 8 Ulcer Photo Documentation taken in the Direct Observation Unit disclosed the sacral pressure ulcer measured 15 cm by 13 cm. On the same day at 4:30 p.m., the Ongoing Pressure Ulcer Photo Documentation, taken in 6 South (Medical-Surgical Unit), revealed the pressure ulcer was a 15 cm by 13 cm at the coccyx and sacral area and was identified as "unstageable" with 80 % necrotic tissue (a wound that contains dead tissue) 15 cm by 13 cm. "Unstageable pressure ulcer" is defined in the facility's "Pressure Ulcer Clinical Practice Guidelines" as full thickness tissue loss in which the base of the ulcer was covered by slough (a layer or mass of dead tissue that is yellow, tan, gray, green or brown) and/or eschar (a dry slough, crust, or scab, that is tan, brown, or black) in the wound bed. A review of the Discharge Summary Notes dated January 16, 2013, indicated the discharge diagnoses included "sacral decubitus ulcer [pressure ulcer], unstageable likely secondary to bedridden state versus drug reaction." A review of the Operation/Procedure Report dated January 27, 2013, at 1:50 p.m., disclosed Patient 1 underwent an excision (definite cutting away of tissue) and debridement (process of removing dead [necrotic]tissue) procedure of the sacral pressure ulcer, Stage III, under local anesthesia. The pressure ulcer was measured 15 cm by 12 cm which involved necrosis (death of skin tissue mainly when insufficient blood and oxygen are supplied) of the skin, subcutaneous fat ("fatty tissue" that lies directly under the skin) and underlying muscle. Another Operation/Procedure Report dated February 22, 2013 at 12:41 p.m., indicated the	E 264		

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E 264	Continued From page 9 patient underwent an excisional debridement procedure of the Stage III sacral pressure ulcer, under local anesthesia. A review of Operation/Report dated March 8, 2013 at 4:20 p.m., disclosed the indication for surgery was Patient 1 had developed a sacral pressure sore. Patient 1 underwent debridement of the sacral pressure ulcer and application of wound VAC device (a device for negative pressure wound therapy consisting of a dressing that is fitted with a tube and attached to the wound VAC) under general endotracheal anesthesia (inhaled anesthesia gases are delivered by a flexible tube through the nose or mouth directly into the windpipe). According to a facility's policy and procedure titled, "Pressure Ulcer or Skin/Wound Conditions-Assessment, Prevention and Management" start date of February 2, 2010 and approve date of October 24, 2012, indicated the purpose was to assess and treat all patients for skin/wound or pressure ulcer conditions, to ensure accurate documentation of skin/wound or pressure ulcer upon admission and throughout hospital stay. The facility utilizes the recommended "SKIN Bundle" which is a series of steps that are implemented for patients who are at risk for developing pressure ulcers. The four key elements of good skin care are Surface selection evaluation for the need for pressure re-distribution bed surface, Keep turning patients (repositioning), Incontinence management, and Nutrition. The SKIN Bundle should be implemented with any patient with Braden Scale/Skin Risk Score of 18 or less. The procedures included completing an initial assessment for patients in the Emergency Department (ED) /Same Day Surgery/Outpatient	E 264		

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E 264	Continued From page 10 Areas (including admitted patients waiting in ED for a room assignment): a head to toe assessment should be completed by the primary nurse, patients should be repositioned every 2 hours, unless contraindicated, and all bony prominence's assessed for at that time. Furthermore, the Initial Skin Assessment should be completed within 2 hours of admission, documenting the patient's history of pressure ulcers, current pressure ulcers, and any abnormalities outlines on the form. Initial head to toe assessment with documentation of Integumentary system (skin, nails, hair) status/condition, and skin abnormalities should be entered in "IView" under "System Assessment" band. The Reassessment of the Skin Risk Screen will be done every shift by the nurse. Control the amount of time the patient is allowed to stay in one position by assessing skin after each position change for erythema. If erythema (skin redness) does not fade, keep area pressure free until erythema is gone and reduce amount of time patient is in that position next time. If redness remains after 30 minutes, this indicates the beginning of a Stage I pressure ulcer. If any other sign of impeding skin breakdown appears (mushy texture, blistering, cracking edema) keep area pressure free until signs have cleared. The facility failed to implement its policy and procedure on assessment, preventions and management of pressure ulcers, including but not limited to failure to complete a "Skin Risk" assessment using the Braden Scale for Patient 1 while in the emergency department, failure to complete an initial assessment of the patient's skin while in the emergency department and document on the "Initial Skin Assessment" form, failure to change the patient's position, while in bed, every two hours as described above, and	E 264		

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E 264	Continued From page 11 failure to evaluate Patient 1 for a pressure-redistribution mattress surface, prior to development of sacral pressure ulcer. This facility failed to prevent the deficiency as described above that caused, or likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code section 1280.3 (g).	E 264		

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