


CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050056 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/24/2016 |
| NAME OF PROVIDER OR SUPPLIER Antelope Valley Hospital | | STREET ADDRESS, CITY, STATE, ZIP CODE 1600 W Avenue J, Lancaster, CA 93534 LOS ANGELES COUNTY | | |
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| | <p>The following reflects the findings of the Department of Public Health during an inspection visit:</p> <p>Complaint Intake Number: CA00451789, CA00333458, CA00451789 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 1276, HFEN</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>Health and Safety Code Section 1280.3(g): 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 is likely to cause, serious injury or death to the patient.</p> <p>Penalty Number: 930013746</p> <p>Health and Safety Code Section 1280.1 (c) 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 is likely to cause, serious injury or death to the patient.</p> <p>Health and Safety Code Section 1279.1 (b) For purposes of this section, "adverse event" includes any of the following: (5) Environmental events including the following: (D) A patient death associated with a fall while being cared for in a health facility.</p> | |  | |

Event ID: W6Y611

2/22/2018

9:46:25AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Michael L. Wall

Michael L. Wall, CEO

3/7/18

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

APOC 3/27/18 Jy

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| | <p>Health and Safety Code Section 1279.1 (c), "The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made."</p> <p>The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made.</p> <p>Health and Safety Code Section 1279.1 (d) "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.</p> <p>T22 70213 Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.</p> <p>T22 70215 Planning and Implementing Patient Care (a) A registered nurse shall directly provide: (1) Ongoing patient assessments as defined in the Business and Professions Code, Section 2725(d). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area. (2) The planning, supervision, implementation, and</p> | | <p>(a) T22-70213 Nursing Policies and Procedures 1. Education and reinforcement of fall policy and procedure emphasizing assessments for risk including medications, secondary diagnosis, implementation of prevention interventions and care planning. 2. Provide 1:1 education and reinforcement of risk assessment to nursing staff when identified incorrect assessment is completed. 3. Discuss with insurance agency representatives available risk assessments to increase patient safety.</p> | <p>03/19/18</p> <p>03/19/18</p> <p>02/28/18</p> | |

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| | <p>evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation.</p> <p>Based on interview and record review, the hospital's professional nursing staff failed to accurately assess Patient 1 for fall risk, implement a plan of care to prevent falls, and advocate for the safety of Patient 1 when multiple factors including medications increased the risk for falling in Patient 1.</p> <p>As a result, Patient 1 fell during the night of 11/3/2012, sustaining fractures of the right leg, the skull and multiple abrasions/bruising on various body parts. Patient 1 subsequently expired in the hospital setting on 11/11/2012.</p> <p>Findings:</p> <p>Per review of the medical record, Patient 1, a 90 year-old woman presented to the hospital's emergency department on 10/31/2012, and was admitted on the same day.</p> <p>The physician documented in the history and physical for Patient 1 the following diagnoses: emphysema (damages the air sacs in your lungs, making you progressively more short of breath); dyspnea (shortness of breath); atrial fibrillation (irregular contractions within the upper chambers of the heart); aortic valve stenosis (heart valve</p> | | <p>4. Request risk assessment of current fall policy and procedure by insurance agency.</p> <p>T22 70215 Planning and Implementing Patient Care</p> <p>1. Implemented electronic care plans for easy accessibility to nursing staff. 03/15/18</p> <p>2. Purchased beds that feature bed alarms to be strategically placed when high fall risk patients are identified. Specialty beds will be utilized in the absence of acquired bed alarms as needed. 05/09/17</p> <p>3. Development of trigger in Cerner Electronic documentation system to initiate and update care plans for high risk fall patients. 10/09/17</p> <p>4. Implement Cerner electronic documentation system on 8/1/18. 09/2017</p> <p>5. Provide 1:1 education and reinforcement of fall policy and procedure to nursing staff when identified incorrect planning and implementation. 03/26/18</p> <p>(b) Initiation of above action items assures patients are assessed and identified for fall risks correctly with implementation of preventive strategies as outlined per policy. This ensures risk assessments and plan of care is implemented to ensure patient's safety. See above for dates</p> |

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| | <p>malfunction).</p> <p>On 11/3/12, the nursing note documentation indicated Patient 1 was found on the floor at the foot of the bed at 4:30 AM.</p> <p>After the incident medical imaging (x-rays) were completed on 11/3/12. Patient 1 was diagnosed with a fracture of the right femur bone (large upper leg bone), and skull fracture with bleeding into the brain.</p> <p>On 11/6/2012, Patient 1 had a surgical procedure to repair the fracture of the right femur bone. Post operatively Patient 1 encountered problems associated with respiratory failure. Documentation in the physician progress notes for 11/8/2012 indicated Patient 1 had a "poor prognosis" for recovery.</p> <p>Patient 1 remained on life support via a breathing machine (ventilator) and repeated attempts failed to wean/remove Patient 1 from the ventilator.</p> <p>Per the physician progress notes, dated 11/10/2012, a decision made by the family in conjunction with the medical team was to discontinue the life support apparatus. Patient 1 expired on 11/11/2012 at 2:57 AM.</p> <p>The California Department of Public Health (CDPH) investigation included a review of the hospital's written policy/procedure (P&P) titled "Fall Prevention and Reduction" (#PC-PC.4.A, dated 1/19/2012). The purpose as stated in the policy and procedure was to prevent and reduce falls. The purpose of the P&P was "to reduce patient fall through a comprehensive</p> | | <p>(c) See above actions and measures.</p> <p>(d) a. Nursing Department Educators will monitor for compliance and provide 1:1 education and reinforcement of Policy and Procedure when non-compliance is identified. b. Nursing Department Educators will periodically screen samples of high risk fall patients for appropriate risk assessment, interventions and care planning. Non-compliance will be reported to Nursing Directors/Managers. Compliance will be reported through QUAPI process.</p> <p>(e) See above.</p> | <p>03/04/18</p> <p>03/26/18</p> |

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| | <p>program of staff awareness, family and patient education and patient safety." Section 2 states "All hospital employees are responsible for taking appropriate actions to minimize the risk of falls. The nursing staff is responsible for the ongoing assessment of a patient's fall risk potential. Then section 3 states "the fall risk screen in the Admission Assessment shall be initiated upon admission on every patient. The Morse Fall scale shall be completed every shift, upon transfer or change in condition."</p> <p>The P&P, section 4, page 2 of the policy indicated that fall prevention and reduction education includes "identifying causes of falls due to medication may include" and then it goes on to list medications that could increase a patient's fall risk.</p> <p>The P&P, section 3, page 4, provided specific direction to the nursing staff to include ongoing patient assessments for fall risk each shift and document accordingly; Implement specific prevention and reduction interventions based on the patient assessment and nursing judgement and document the interventions; educate patient and family related to fall prevention and document in the medical record. Per the P&P attachment B, patients assessed at 25 points or more will have basic (low level) interventions in place and consisting of a yellow band placed on the arm/wrist area to alert all staff of the risk for fall, along with yellow nonskid sock slippers and signage outside the patient room(s). The P&P also indicated the use of a pressure sensor alarm on the bed for a "High" fall risk patient.</p> | | | |

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| | <p>The professional nursing staff assessed patients for fall risk utilizing the Morse Fall scale. This is a point system with six categories. The procedure assigned various point values ranging from zero to thirty in each category, and the cumulative point total placed individual patients into low risk at 0 to 24 points, medium risk at 25 to 44 points, and high risk at 45 and higher.</p> <p>The categories include:</p> <ol style="list-style-type: none"> 1. History of falls. 2. Secondary diagnosis (any additional medical or nursing diagnosis that may impact mobility or ability to perform activities of daily living, e.g. heart failure or emphysema.) 3. Ambulatory aspects such as cane, crutches, walker, and furniture in the room. 4. Intravenous access. 5. Gait function (ability to walk) - Patient 1's gait function (ability to walk) was consistently assessed by the nursing staff as "weak." 6. Mental status. <p>The nursing note documentation provided RN 1 assessed Patient 1 on 11/1/2012 at 2:43 AM, and assigned a "high" fall risk value of 45 points (indicating a high fall risk).</p> <p>RN 2 assessed Patient 1 on 11/1/2012 at 8:30 AM, and again assigned a "high" fall risk value of 45 points (indicating a high fall risk).</p> | | | |

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| | <p>The review of the medical record failed to demonstrate that a specific plan of care related to Patient 1's high fall risk was developed or initiated.</p> <p>There was no evidence the intervention of a pressure sensor alarm was implemented prior to the 11/3/2012 fall/injury event involving Patient 1.</p> <p>After the fall event on 11/3/2012, a written plan of care related to fall prevention was dated 11/3/2012 and timed at 7 AM.</p> <p>The secondary diagnosis category as described in the initial physician history and physical for Patient 1 was documented in the medical record as emphysema, dyspnea, atrial fibrillation and aortic valve stenosis.</p> <p>(A secondary diagnosis is any additional medical or nursing diagnosis that may impact mobility or ability to perform activities of daily living, e.g. heart failure or emphysema.)</p> <p>RN 3 was interviewed on 8/15/16 at 11 AM, and confirmed caring for Patient 1 on 11/1/12. Based on the medical record available, RN 3 was able to validate the minimal level measures for fall prevention were in place, but beyond that was unable to recall if any interventions including a pressure sensor alarm was utilized related to fall prevention.</p> <p>RN 3 confirmed if the pressure sensor alarm had been used it would have been documented in the nursing notes. RN 3 confirmed she had downgraded</p> | | | | |

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| | <p>Patient 1's fall risk assessment to "medium" on 11/1/2012 at 10:12 AM.</p> <p>RN 1 was interviewed on 8/17/16 at 7:30 AM, related to the downgraded fall risk assessment. RN 1 was asked why the category of "Secondary Diagnosis" was given zero point value, when RN 1 had assigned the 15 points in the respective category just 18 hours earlier. RN 1 was unable to provide a rationale for the elimination of the 15 points for the secondary diagnosis category. There was no documentation in the medical record to indicate why a zero point value was assigned.</p> <p>The interviews and review of the nursing note documentation with the RN 1 and 3, the Director of Regulatory Affairs, validated only the minimum low-level fall prevention interventions were in place for each nursing shift.</p> <p>The interventions were limited to the use of a (yellow) armband designating fall risk, signage outside the door and non-skid footwear, instead of high fall risk or medium fall risk interventions pursuant to the fall risk assessment.</p> <p>Family Member (FM) 1 for Patient 1 was interviewed on 8/4/16 at 10:40 AM, regarding the observations of yellow armband/and yellow nonskid footwear on Patient 1. FM 1 stated she had visited Patient 1 on a daily basis, but never observed the yellow nonskid footwear or a yellow armband in place.</p> <p>FM 1 distinctly recalled looking at Patient 1's arms and observing only the hospital identification</p> | | | | |

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| | <p>bracelet. FM 1 stated that she had routinely looked at the arms of Patient 1, because of a previous different incident in which a different family member had the wrong patient identification bracelet in place.</p> <p>The hospital written P&P also indicated that a review of medications was to be considered in regards to patient fall risk and assessment. There existed 11 categories of medications in the P&P that could increase a patient's risk of falling, and Patient 1 was receiving six of the medication categories outlined in the P&P.</p> <p>Analgesics - Percocet (pain medication) Laxatives - Lactulose (laxative) Antihypertensive - Diltiazem and Lisinopril (blood pressure) Diuretic - furosemide (increased urination) Sedative/Hypnotic - Ambien (sleeping pill) Polypharmacy - Patient 1 received 11 medications from the above categories on 11/3/12 prior to the fall incident:</p> <p>RN 5's assessment dated 11/2/12 at 8:30 AM, documented additional factors for fall risk related to "urinary urgency, pain" and "effect of meds." RN 5 did not indicate any follow up related to these concerns nor increase Patient 1's fall risk rating.</p> <p>RN 6's assessment dated 11/3/12 at 12:06 AM; completed 4 hours prior to the fall incident documented the same risk factors for fall risk related to "urinary urgency, pain" and "effect of meds." RN 6 did not indicate any follow up related</p> | | | |

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| | <p>to these concerns nor increase Patient 1's fall risk rating.</p> <p>The aforementioned additional fall risk factors did not carry any point values, thereby, Patient 1 remained in the medium fall risk category.</p> <p>This facility failed to accurately assess Patient 1 at high risk for falls as indicated by the Fall Risk assessment forms dated November 2 and 3, 2012 and Patient 1's condition at the time of the assessment. The facility's failure to accurately assess Patient 1 at High Risk for Falls and implement a plan of care with interventions for the prevention of falls resulted in Patient 1 sustaining a fall that resulted in a fracture of the right leg, the skull, and multiple abrasions/bruising on various body parts. Patient 1 subsequently expired in the hospital setting on 11/11/2012.</p> <p>The deficiency as described above caused, or is 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 1280.1(c).</p> <p>This facility failed to prevent the deficiency(ies) as described above that caused, or is 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).</p> | | | | |

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