

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2009
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL WESTMINSTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 HOSPITAL CIRCLE, WESTMINSTER, CA 92683 ORANGE COUNTY		
(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
	<p>Continued From page 1</p> <p>(1) Nutritional care shall be integrated in the patient care plan.</p> <p>70273(i)(2) Dietetic Service General Requirements (i) Nutritional Care.</p> <p>(2) Observations and information pertinent to dietetic treatment shall be recorded in patient's medical records by the dietitian.</p> <p>The above regulation was NOT MET as evidenced by:</p> <p>Based on observation, interview, and review of the medical record and the hospital's P&P (policies and procedures), the hospital failed to complete weekly and daily wound assessments; to provide pressure relieving devices to promote wound healing and to prevent development of further pressure ulcers and to develop and revise the care plan to address appropriate interventions as to how to prevent development of new pressure ulcers. In addition, the hospital failed to follow their P&P on nutritional care to ensure the care plan was developed and revised to address the significant weight loss of 63.8 lbs (pounds) for Patient A with appropriate interventions to prevent further weight loss and to promote wound healing. The RD (registered dietitian) and the physician were not notified of this significant weight loss to reassess and intervene in a timely manner to maintain adequate nutrition for Patient A. Additionally, the hospital staff failed to timely report the pressure ulcers of Stage 3 or higher and the presence of two or more pressure ulcers through the hospital's event reporting system.</p>		<p>70213(a) Nursing Service Policies and Procedures</p> <p>Systemic Changes to Prevent Recurrence:</p> <p>The nursing staff were re-educated to the policy and procedures related to Wound Assessment and Classification, and Wound Treatment. The organization implemented a re-education program on wound care assessment and management. A corporate consultant for wound care presented education related to Pressure Ulcer Prevention (PUP). In addition, education was provided for accurate wound staging based on the National Pressure Ulcer Advisory Panel (NPUAP) definitions and descriptions of wounds. The re-education process also included assessment and documentation of pressure ulcers, as well as, the requirement to document daily assessments during dressing changes and to include any equipment used to prevent either the progression of existing wounds, or prevention of further wounds.</p> <p>Monitoring:</p> <p>10-15 charts per month are randomly chosen to audit pressure ulcer patients. The audit focuses on the following elements of wound care:</p> <ol style="list-style-type: none"> 1. Ensure inter-rater reliability with wound assessments and documentation amongst wound care team members and nursing staff. 2. Ensure wounds and nutritional needs are accurately addressed via the IDT process. 3. Ensure appropriate care plans are initiated and include interventions for further skin breakdown as necessary, and prevention of new wounds. <p>Responsible Role: Chief Clinical Officer</p>	<p>12/31/08</p> <p>01/05/09</p>
Event ID:8YKF11		3/3/2010	9:04:15AM	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

2009 MAR 26 AM 9:56

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	<p>Continued From page 2</p> <p>Patient A was admitted to the hospital on 4/28/08, with one pressure ulcer on the tongue. Patient A was assessed to be at risk for skin breakdown. Due to the hospital's failures to provide appropriate preventive devices, to assess the skin daily and weekly, and to revise the care plan accordingly, Patient A developed multiple pressure ulcers and wounds during the hospital stay. Patient A was admitted to the hospital with the weight of 321.3 lbs. On 7/12/08, Patient A was identified to have a significant weight loss of 63.8 lbs. However, the hospital failed to assess and intervene timely to maintain adequate nutrition to promote wound healing for Patient A.</p> <p>These failures resulted in Patient A developing 11 pressure ulcers and sustaining a significant weight loss by 8/22/08.</p> <p>Findings:</p> <p>According to the NPUAP (The National Pressure Ulcer Advisory Panel), a Stage II pressure ulcer is defined as a partial thickness loss of skin presenting as a shallow open ulcer with a red pink wound bed, without dead tissue. A Stage III pressure ulcer is defined as a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed and slough (dead tissue in the process of separating from viable portions of the body) may be present but does not obscure the depth of tissue loss. An unstageable pressure ulcer is described as having full thickness tissue loss in which the base of the</p>		<p>70215(b) PLANNING AND IMPLEMENTING PATIENT CARE</p> <p>Immediate Correction Action: The care plans for patients with wounds were reviewed and revised as necessary to ensure the plan of care reflected the patients' individualized needs.</p> <p>Systemic Changes to Prevent Recurrence: The hospital changed to a new, softer under pad (Chux) product to facilitate wound prevention. A 'Weekly Wounds Report' was developed and is used by the wound care team during rounds to ensure essential elements of wound care are monitored and documented, including: Braden Scale score, mattress type, date of wound care physician consultation, and the Bates-Jensen wound improvement score. The organization developed and implemented a 'War on Wounds' or WOW program. This is a process which begins at the time of admission when a patient is assessed as at risk for skin breakdown to ensure appropriate preventive measures are initiated. These at risk patients are placed on a 'Watch List' to ensure the Wound Care Team rounds weekly to assess and document progress. Additionally, and as part of the WOW program, the wound care physician rounds with the wound care team on a weekly basis. During the implementation of the WOW program, the staff were also re-educated to the policy and procedure 'Event Reporting System,' with regards to the requirement to report hospital acquired Stage 3 or higher pressure ulcers, or the presence of two or more wounds at any level.</p> <p>Monitoring: 10-15 charts per month are randomly chosen to audit pressure ulcer patients. The audit focuses on (Continued to page 4)</p>	<p>12/2008</p> <p>03/2009</p> <p>02/2009</p>
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	<p>Continued From page 3</p> <p>ulcer is covered by slough (yellow, tan, gray, green or brown) and dead tissue.</p> <p>According to the hospital's P&P (policy and procedures) titled "Wound Assessment and Classification," all wounds would be assessed upon admission, upon occurrence, weekly, during dressing changes, and with any significant change. Assessment would include determining and documenting the cause of the wound at time of the assessment. The IDT (interdisciplinary team) goals and treatment plans would be initiated, updated, and documented in the patient's care plan.</p> <p>According to the hospital P&P titled "Wound Treatment," a wound treatment care plan would be initiated for patients upon development of a wound and the plan of care would be evaluated and revised every two weeks.</p> <p>According to the hospital's P&P titled "Weighing Patient," patients with significant weight changes (a weight gain or loss of 10 pounds or more or a 5% gain or loss) must be re-weighed to confirm the change. The change is to be reported to the RN (Registered Nurse) and the nurse is to report the weight change to the RD (Registered Dietician) and the patient's physician.</p> <p>According to the hospital's P&P titled "Nutrition Care Process," the IDT process is to address the nutritional care of patients. The process consists of screening, assessing nutrition needs, developing a plan for nutrition therapy, and monitoring the patient's response to nutrition care.</p>		<p>the following elements of wound care:</p> <ol style="list-style-type: none"> 1. Ensure all wounds are addressed during the weekly wound care rounds by the wound care team. 2. Ensure inter-rater reliability with wound assessments and documentation amongst wound care team members and nursing staff. Education related to any discrepancies will occur at the point of care to assure nursing staff receive timely feedback. 3. Ensure wounds and nutritional needs are accurately addressed via the IDT process. 4. Ensure appropriate care plans are initiated and include interventions for further skin breakdown as necessary, and prevention of new wounds. <p>Responsible Role: Chief Clinical Officer</p>	<p>2010 MAR 26 AM 9:56</p>
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	<p>Continued From page 4</p> <p>According to the hospital's P&P titled "Event Reporting System," all hospital personnel are responsible for reporting an event in a timely and efficient manner. The purpose of event reporting is to improve patient care as to how and why an event occurred and how to prevent a similar event from occurring. The examples of events reportable in the P & P include the hospital's acquired Stage 3 or higher pressure ulcers or the presence of two or more wounds at any level. Reporting of hospital acquired Stage 3 pressure ulcers is also specifically required by California Health and Safety Code 1279.1(b)(4)(F).</p> <p>These policies and procedures for patient care were not implemented for Patient A as follows:</p> <p>On 10/17, 11/6, and 11/11/08, Patient A's medical record was reviewed. Patient A was admitted to the hospital on 4/28/08. The admitting diagnoses included encephalopathy (a type of brain injury), post cardiopulmonary arrest, morbid obesity, respiratory failure, and seizure disorder.</p> <p>The nursing admission assessment, dated 4/28/08, showed Patient A was comatose and had a pressure ulcer on the tongue. Patient A was assessed to have a Braden scale score (a risk assessment for skin breakdown) of nine. A score of 16 or less indicates the patient is at high risk for skin breakdown. The patient's admission weight was 321.3 lbs.</p> <p>On 4/28/08, a plan of care was developed to</p>		<p>70273(i)(1) DIETETIC SERVICE GENERAL REQUIREMENTS</p> <p>Immediate Correction Action: Records were reviewed for patients with wounds to ensure nutritional care appropriately addressed wound healing and prevention, and physician notification for any patients identified with significant weight loss (> 10lbs, or 5%) was completed and documented.</p> <p>Systemic Changes to Prevent Recurrence: The Registered Dietitians (RD) were re-educated to the organizational policy 'Nutrition Therapy for Adult Patients with Pressure Ulcers' which includes the need for a wound care treatment plan initiation at time of admission or upon development of a wound. Education also focused on nutrition related risk factors for wound development. In addition, the RD staff were re-educated regarding the practice of integrating patients' nutritional needs in the Interdisciplinary Team (IDT) process with subsequent updates to individual plans of care related to nutritional needs and wound prevention and healing as appropriate.</p> <p>Monitoring: 10-15 charts per month will be randomly chosen to audit pressure ulcer patients. The audit will focus on the following elements:</p> <ol style="list-style-type: none"> 1. Ensure wounds and nutritional needs are accurately addressed via the IDT process. 2. Ensure accurate documentation of nutrition's plan and treatments based on patients' unique needs. <p>Responsible Role: Director of Nutrition Services</p>	<p>03/12/10</p> <p>03/31/10</p>
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	<p>Continued From page 5</p> <p>address the pressure ulcer on the tongue and for the potential for impaired skin problems. Interventions included repositioning the patient, keeping the pressure off the patient's heels at all times, inspecting the patient's skin during position changes, and maintaining a clean dry environment for the patient.</p> <p>The wound care admission assessment, dated 4/29/08, showed documentation that Patient A had red skin and a small purple lesion on the rectal area.</p> <p>On 4/29/08, the RD documented that Patient A was identified as a high risk for poor nutrition and to have a pressure ulcer on the tongue. The patient's other skin breakdown was not assessed. The patient's admission weight was 321.3 lbs (equal to 146.05 kgs (kilograms)). The RD documented Patient A's daily nutritional needs included 1750-2190 calories, 117-146 grams of protein, and 5840 ml (milliliter) of fluids. The RD also documented the patient's current daily tube feeding (Glucerna) provided 960 calories and 40 grams of protein (0.8-1.0 gram per kg of body weight) which did not meet the patient's daily nutritional needs. The patient had an albumin level of 1.5 g/dl (normal 3.3 to 4.8 g/dl). The RD recommended to change the patient's feeding formula to Jevity at a rate of 50ml/hour, and to add Beneprotein (protein power supplement). The recommendation was discussed with the nursing staff. Patient A would be monitored as a high nutritional risk patient.</p> <p>The nursing progress notes, from 5/4/08 to 5/6/08,</p>		<p>70273(i)(2) DIETETIC SERVICE GENERAL REQUIREMENTS</p> <p>Immediate Correction Action: Records were reviewed for patients with wounds to ensure nutritional care appropriately addressed wound healing and prevention, and physician notification for any patients identified with significant weight loss (> 10lbs, or 5%) was completed and documented.</p> <p>Systemic Changes to Prevent Recurrence: The Registered Dietitians (RD) were re-educated to the organizational policy 'Nutrition Therapy for Adult Patients with Pressure Ulcers' which includes the need for a wound care treatment plan initiation at time of admission or upon development of a wound. Education also focused on nutrition related risk factors for wound development.</p> <p>Additionally, the RDs were re-educated to the requirement to include accurate weights in all nutrition assessments, and to individualize the plan of care based on accurate caloric requirements and protein needs for wound healing.</p> <p>Monitoring: 10-15 charts will be randomly chosen to audit pressure ulcer patients. The audit will focus on the following elements:</p> <ol style="list-style-type: none"> 1. Ensure wounds and nutritional needs are accurately addressed via the IDT process. 2. Ensure nutritional assessments include accurate patient weights, caloric requirements and protein necessity for wound healing and prevention. <p>Responsible Role: Director of Nutrition Services</p>	<p>03/12/10</p> <p>03/26/10</p>
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	<p>Continued From page 6</p> <p>showed documentation that the nursing staff repositioned the patient on a two-hour schedule using pillows and heel protectors to elevate the lower legs. The nurse documented the patient was positioned on the back, left, and right sides.</p> <p>The nursing progress notes, dated 5/6/08, showed documentation Patient A was identified with a skin tear on the right buttock. The patient had a regular mattress.</p> <p>There was no documented evidence that the hospital provided a pressure relieving bed to help relieve the pressure since the patient was identified to have a high risk for pressure ulcer development and to have skin breakdown on the right buttock and the rectal area.</p> <p>The nursing progress notes, dated 5/7/08, showed the patient was identified with skin abrasions and a new pressure ulcer on the right and left buttocks. No stage for these new pressure ulcers was documented. In addition, the nurse documented the nurse attempted to contact the wound care team to evaluate the patient's skin issues in order to obtain further wound care instructions for the patient. On 5/7/08, the RD did not document the weight of the patient or the patient's skin breakdown during the re-assessment of the patient.</p> <p>The Wound Care Reassessment, dated 5/8/08, showed Patient A was assessed as having three Stage II pressure ulcers to the sacrum, coccyx, and left buttock and an unstageable pressure ulcer to the right buttock. There was no documented</p>			2010 MAR 26 AM 9:56
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	<p>Continued From page 7</p> <p>evidence that the hospital revised the patient's plan of care to address appropriate interventions as to how to prevent the development of further pressure ulcers.</p> <p>On 5/14/08, the RD documented the assessment of the patient's nutrition and the patient had met the estimated nutritional needs. There was no documented evidence that the RD had addressed the patient's pressure ulcers and wounds as to what interventions were to be implemented to help promote wound healing.</p> <p>The Wound Care Reassessment, dated 5/15/08, showed the four pressure ulcers on the coccyx, sacral, right, and left buttocks had combined into one large unstageable pressure ulcer. Further record review showed Patient A developed more pressure ulcers: a stage IV pressure ulcer to the left ear lobe, an unstageable pressure ulcer to the left hip, and an unstageable pressure ulcer to the occipital area (back of the head).</p> <p>On 5/28/09, the RD documented the patient had received the recommended feeding formula. The patient weighed 323.5 lbs. There was no documented evidence that the RD had re-assessed the patient to meet the caloric and protein needs for the patient who had multiple wounds.</p> <p>Review of the hospital's guidelines for medical nutritional therapy for wounds showed that patients with wounds needed 21 calories/kg, and 1.2 to 2.0 gm/kg for actual body weight. In addition, the guidelines instructed the RD to continually</p>			<p>2010 MAR 26 AM 9:56</p>
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	<p>Continued From page 8</p> <p>re-evaluate nutritional needs and interventions and adjust the patient's diet accordingly.</p> <p>The Wound Care Reassessment, dated 6/2/08, showed Patient A developed a wound to the occipital area, an unstageable pressure ulcer to the left ear, an unstageable pressure ulcer to the sacrum, and a Stage II pressure ulcer to the left leg. The nurse documented the patient was on a low air loss mattress.</p> <p>The Wound Care Reassessment, dated 6/4/08, showed Patient A developed a blister to the left leg.</p> <p>The Wound Care Reassessment, dated 6/7/08, showed Patient A developed an unstageable pressure ulcer to the left ear.</p> <p>The Wound Care Reassessment, dated 6/12/08, showed Patient A developed a unstageable pressure ulcer to the parietal (middle top of the head) area, a Stage II pressure ulcer to the left ear, a Stage II pressure ulcer to the left hip, and a Stage IV pressure ulcer to the sacrum.</p> <p>The Wound Care Reassessment, dated 6/16/08, showed Patient A developed a Stage II pressure ulcer to the left hip. There was no documented evidence the hospital updated the plan of care to address use of pressure relieving devices to position the patient to prevent progression of existing pressure ulcers or development of new pressure ulcers.</p> <p>On 6/16/08, the RD documented the patient had no</p>			2010 MAR 26 AM 9:56

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2009	
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL WESTMINSTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 HOSPITAL CIRCLE, WESTMINSTER, CA 92683 ORANGE COUNTY		
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	<p>Continued From page 9</p> <p>new nutritional problems and the feeding regimen had met the patient's estimated nutritional needs. The RD documented that the patient received Jevity 1.5 with the rate of 50 ml per hour and three scoops of Beneprotein three times daily. The patient weighed 333.4 lbs. Again, there was no documented evidence that the care plan was revised to address the patient's further nutritional needs for wound healing. There was no documented evidence the patient's wounds and nutritional needs were addressed in the IDT for appropriate interventions and goals.</p> <p>The Wound Care Reassessment, dated 6/23/08, showed the pressure ulcer on the left ear had progressed from a Stage II to an unstageable pressure ulcer. In addition, Patient A developed a moist pink abrasion with scattered yellow tissue to the left scapula (shoulder).</p> <p>The Wound Care Reassessment, dated 6/27/08, showed documentation that Patient A developed a superficial abrasion to the left thigh. The Wound Care Reassessment, dated 7/2/09, showed documentation that Patient A developed a Stage II pressure ulcer on the left hip.</p> <p>On 7/12/08, the entry at 0600 hours by the nursing staff showed the patient's weight was 314.8 lbs. However, another entry by the nursing staff at 1500 hours showed the patient's weight was 251 lbs. There was no documentation to explain the discrepancy between these weights. There was no documentation another weight was taken to confirm the patient had lost 82.4 lbs from the previous</p>			2010 MAR 26 AM 9:56

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	<p>Continued From page 10</p> <p>month, 6/08. There was no documentation the physician or the RD was notified of the 82.4 lb weight loss (equal 24.7%).</p> <p>On 7/21/08, the RD documented the patient's weight was 251 lbs and the feeding regimen had met the patient's estimated needs. There was no documented evidence the RD had re-assessed the patient in regards to a significant weight loss of 82.4 lbs in less than a month and the development of multiple wounds.</p> <p>On 7/23/08, the Stage II pressure ulcer on the left hip had progressed to an unstageable pressure ulcer. The care plan interventions during this period were to avoid positioning the patient on the back due to a large wound on the sacrum. There was no documented evidence to show the patient's plan of care was revised to address the new pressure ulcer on the left hip and what interventions were to be utilized to help promote the healing of these pressure ulcers.</p> <p>The nursing progress notes and CNA (Certified Nursing Assistant)'s activity records, showed on 6/29/08, 7/3/08, 7/16/08, 7/17/08, and 7/26/08, the nursing staff were following the care plan to turn the patient to the left and right sides.</p> <p>The Wound Care Reassessment, dated 8/1/08, showed Patient A received treatments for the pressure ulcers on the coccyx, occipital, left ear, left shoulder, and left hip.</p> <p>On 8/12/08, the RD documented the actual weight</p>			2010 MAR 26 AM 9:56
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	<p>Continued From page 11</p> <p>recorded was 257 lbs as of 8/12/08.</p> <p>On 8/19/08, the RD documented the RD was not notified of the patient' weight of 251 lbs on 7/12/08, and was doubtful of the accuracy of the weight. However, there was no evidence of further investigation for the weight differences from 333.4 lb in 6/08 and 251 lb in 7/08.</p> <p>The Wound Care Reassessment, dated 8/22/08, showed the patient was identified with a new unstageable pressure ulcer on the right hip. Again, there was no documented evidence to show the patient's plan of care was revised to address all pressure ulcers and what interventions were to be utilized to help promote the healing of these pressure ulcers and to prevent development of new pressure ulcers. There was no documented evidence the hospital re-evaluated and discussed the patient's wounds in the IDT meetings to formulate an effective treatment plan with goals as to how to promote wound healing and prevent new wound development.</p> <p>Review of the weekly Wound Care Reassessment, from 4/28/08 to 8/22/08, failed to show documentation that the wound care nurses and the direct patient care nurses had re-assessed all of the above pressure ulcers every week and every day. For example, there was wound care documentation on 6/12/08, for the unstageable pressure ulcer on the occipital area. However, there was no documented evidence of weekly wound assessments for the pressure ulcer on the occipital area during the weeks of 6/23/08, 7/2/08, 7/17/08,</p>			2010 MAR 26 AM 9:56

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	<p>Continued From page 12</p> <p>8/1/08, and 8/9/08.</p> <p>Review of the Wound Care Assessment, from 4/28/08 to 8/22/08, showed the patient acquired the following wounds during the hospital stay:</p> <ul style="list-style-type: none"> - A skin tear to the right buttock on 5/6/08. - A skin abrasion and a pressure ulcer to the right and left buttocks on 5/7/08. - Three Stage II pressure ulcers to the sacrum, coccyx, and left buttock and an unstageable pressure ulcer to the right buttock on 5/7/08. - An unstageable pressure ulcer to the sacral area, a stage IV pressure ulcer to the left ear lobe, an unstageable pressure ulcer to the left hip, and an unstageable pressure ulcer to the occipital area on 5/15/08. - A blister on the left leg on 6/4/08. - An unstageable pressure ulcer on the left ear on 6/7/08. - An unstageable pressure ulcer to the parietal of the head, a Stage II pressure ulcer to the left ear, a Stage II pressure ulcer to the left hip, and a Stage IV pressure ulcer to the sacrum on 6/12/08. - A Stage II pressure ulcer to the left hip on 6/16/08. - A Stage II pressure ulcer progressed to an unstageable pressure ulcer to the left ear and a moist pink abrasion with scattered yellow tissue on the left scapula on 6/23/08. - A superficial abrasion on the left thigh area on 6/27/08. - A Stage II pressure ulcer to the left hip on 7/2/09. - An unstageable pressure ulcer on the right hip 8/22/08. 			2010 MAR 26 AM 9:56

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	<p>Continued From page 13</p> <p>On 8/26/08, the RD documented that the patient received 1800 calories and 76 grams of protein from the feeding formula everyday. The RD documented these calories and protein amounts might be less than patient's nutritional needs. According to the initial nutritional assessment, dated 4/29/08, the patient's daily nutritional requirements were estimated as 1750 -2190 calories and 117-146 grams of protein. Therefore, the patient currently received insufficient amounts of protein as assessed. The RD also documented the RD was to monitor and adjust the nutritional needs as indicated. There was no documented evidence that the RD revised the plan of care to address the need for more protein in the feeding formula to help maintain Patient A's weight and promote wound healing. There was no documented evidence the patient's wounds and nutritional needs were addressed in the IDT for appropriate interventions and goals.</p> <p>On 9/2/08, the RD documented Patient A needed to be re-weighed. The RD also documented the RD had to wait for the weight to check for the adequacy of the tube feeding. However, there was no documented evidence the RD reassessed the patient's feeding formula to ensure the patient received adequate nutrition.</p> <p>On 9/8/08, the RD documented Patient A had diarrhea continuously and pressure ulcers. The new weight was not available. The RD documented the patient's tube feeding appeared to meet the estimated nutritional needs. However, there was no</p>			2010 MAR 26 AM 9:56

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	<p>Continued From page 14</p> <p>documented evidence the RD had specified what the estimated nutritional needs were for the patient at this time. There was no documentation of the patient's current weight to identify whether the patient had lost any more weight. In addition, there was no documented evidence the RD had monitored, re-assessed, and revised the patient's plan of care to address the weight loss and the needs of nutrition to prevent further weight loss and to promote wound healing.</p> <p>On 10/17/08 at 0925 hours, an interview with the Director of Quality Management showed there was no documentation the above wounds, other than #12, had been reported through the hospital's event reporting system.</p> <p>On 10/17/08 at 1225 hours, the patient was observed lying on a pressure relieving air mattress. During a concurrent interview with the family member at the bed side, the family member stated sometimes the mattress did not function, the mattress would become flat. According to the family member, when that happened the staff turned the patient with pillows.</p> <p>On 10/17/08 at 1430 hours, during an interview, the Manager of the Critical Care Unit stated Patient A was an obese patient who frequently perspired heavily. The patient required linen changes frequently. While discussing the patient's weight loss, the Manager stated the patient visually looked like there had been a significant weight loss.</p> <p>On 10/17/08 at 1435 hours, during an interview with</p>			2010 MAR 26 AM 9:56
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	<p>Continued From page 15</p> <p>the Manager of the Critical Care Unit and the Wound Care Coordinator, they stated the hospital had an IDT conference on a weekly basis for patients' wound care management. The committee of the IDT included the unit supervisor, primary care nurses, the wound care team, the nutritional consultant, pharmacist, and the rehabilitation team. The team would discuss the current treatment and make recommendations. However, there was no documented evidence this happened for Patient A.</p> <p>On 11/6/08 at 1400 hours, when asked how often Patient A was to be weighed the Manager of the Critical Care Service stated the patient was supposed to be weighed weekly. The Manager could give no reason as to why the patient was not weighed weekly or why no one had been notified of the significant weight loss identified on 7/12/08. The Manager stated she identified the difference in weight later on. The Manager stated she expected the staff to notify the physician and the RD of the weight loss of 82.4 lbs.</p> <p>On 11/6/08 at 1410 hours, an interview was conducted with Patient A's Case Manager (CM). During the interview, the CM reviewed the record and stated there had never been a formal IDT conference for this patient. The CM explained to the surveyor that the CM collected Patient A's medical progress information from the physical therapy, occupational therapy, nutritional therapy, and nurses. The CM submitted a report to the insurance company. The CM did not recall any IDT conference being initiated for Patient A and the medical record failed to show documentation of an</p>			2010 MAR 26 AM 9:56	
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	<p>Continued From page 16</p> <p>IDT meeting.</p> <p>On 11/11/08 at 1600 hours, during an interview, the RD stated Patient A's IDT meeting was weekly and for this patient was led by the CM. The attendees all signed an attendance sheet.</p> <p>On 11/12/08 at 1130 hours, during an interview, the RD stated she and another RD had reassessed Patient A on a weekly basis. The weekly assessments included weekly weights, laboratory data, medical condition progress, and fluid intake and output to determine the patient's nutritional needs. The RD collected the patient's medical progress information by interviewing the care staff and reviewing the medical record. The RD stated she might have been aware of the patient's pressure ulcers if she could review the patient's medical record. However, when the RD reviewed the patient's medical record the RD could not find any documentation that the pressure ulcers were addressed during the dietary assessments to identify further nutritional needs for wound healing.</p> <p>On 11/24/08 at 1420 hours, when questioned about the patient's weights and weight discrepancies, the RD stated she missed it. When asked what was done when weights were not recorded in the medical record, the RD stated that she waited for the next week to review.</p> <p>The hospital's failure to implement their P&Ps regarding wound and nutritional assessments, revision of the care plan to address appropriate interventions to promote wound healing, adequate</p>			2010 MAR 26 AM 9:56	

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	<p>Continued From page 17</p> <p>nutrition and to prevent the development of further pressure ulcers, and reporting the acquired pressure ulcers and wounds through the event reporting system is a deficiency that has 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 1280.1(c).</p>			2010 MAR 26 AM 9:56
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