### Statement of Deficiencies

#### Identifications
- **Provider/Supplier/Clinic**: California Health and Human Services Agency, Department of Public Health
- **Multiple Construction**: A. Building, D. Wing
- **Identification Number**: 009009
- **Date Survey Completed**: 02/23/2015

#### Provider or Supplier
- **Name**: Queen of the Valley Medical Center
- **Address**: 1000 Trancas St, Napa, CA 94559-2906

#### Summary Statement of Deficiencies
- **Provider's Plan of Correction**

#### Findings

**Immediate Follow Up Actions:**

1. The CMO/COO and Nursing Leadership including the CNO, 2North Nursing manager, Director of Cardiovascular services, Director of Staff Education, Advanced Clinical Nurse Practitioner (ACNP), and representatives for Performance Improvement (PI), and Risk Management commenced an intense investigation and a Root Cause Analysis to review these events on 10/06/13. It was identified that education and process changes were needed to improve patient assessment-assessments and documentation, plan of care documentation, plan of care implementation, physician notification, and staff competencies for patient(s) having multiple/complex facial fractures including wired jaw. A focused education and training event was initiated.

**Abbreviations:**
- BOT - Board of Trustees
- CBO - Competency Based Orientation
- CQC - Clinical Quality Council
- CMO/COO - Chief Medical Officer/Chief Operating Officer
- CNO - Chief Nursing Officer
- MSEC - Medical Staff Executive Committee
- MSQC - Medical Staff Quality Council
- RT - Respiratory Therapy/Therapist

**Penalty Number:** 110011404

#### Event Information
- **Event ID:** EWKP11
- **Date:** 07/24/2015
- **Time:** 11:55:26AM

#### Laboratory Director's or Provider/Supplier Representative's Signature

By signing this document, I am acknowledging receipt of the entire citation packet.

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 required to continued program participation.
### Summary Statement of Deficiencies

**Event ID:** E292  
**Complete Date:** 11/25/2015

- **See - E292**
- **E.292 T22 DIV 6 CH1 ART 3 - 70215(a)(2) Planning & Implementing Patient Care**

A registered nurse shall directly provide:
- The planning, supervision, implementation, and 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 liveness, certification, level of validated competency, and/or regulation.

Based on staff, family interviews, record review, and document review, the hospital failed to ensure that nursing staff provided ongoing assessments for Patient 1's change of condition for increased anxiety, airway patency (maintaining open airway), bleeding, and trouble breathing and these changes were reported promptly to the physician for one patient (Patient 1). These failures delayed recognition of Patient 1's deteriorating medical condition that resulted in Patient 1 to bleed down the back of her throat, had a respiratory arrest and sustained an anoxic brain injury. Adequate oxygen is vital for the brain. When oxygen levels are significantly low for four minutes or longer, brain cells begin to die and after five minutes permanent brain injury can occur. Anoxic brain injury is a serious, life-threatening injury. Patient currently is in a persistent vegetative state. These failures were violations of Section 70216(a)(1)(2) of Title 22 of

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### Provider's Plan of Correction

- **(a)** patient needs are met by ongoing assessment of patients' needs
- **(b)** patient's plan of care:
  - is based on assessing the patient's nursing care needs
  - develops appropriate nursing interventions in response to identified nursing care needs, and
  - is kept current by ongoing assessments and documentation.
- **(c)** physicians will be notified about significant change in patient's condition in a timely manner.
- **(d)** sufficient numbers, types, and qualifications (training and experience) of nursing personnel are available to respond to the appropriate nursing needs and care for the patients with multiple/complex facial fractures including jaw wiring.
- **(e)** the medical center provides nursing services for patients with multiple/complex facial fractures including jaw wiring 24 hours a day, 7 days a week.

**Mandatory Education Plan was developed for applicable 2NorT/Telemetry/Step Down unit, Post Anesthesia Care Unit (PACU), and Intensive Care Unit (ICU) nursing staff to ensure nursing staff have competencies to provide ongoing assessments and reassessments which recognize patient's change of condition; thereby, ensuring changes are reported promptly to the physician and the patient's care plan is individualized to address the patient's needs.**

This education plan included the following elements:

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### Initial Survey

- **(a)** A building
- **(b)** T22
- **(c)** CH1
- **(d)** ART 3
- **(e)** 70215(a)(2) Planning & Implementing Patient Care

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**Note:** The provided text is a transcription of the document, focusing on the summary of deficiencies and the provider's plan of correction. The detailed plan of correction includes specific actions and references to relevant sections of Title 22 regulations.
the California Code of Regulations and were deficiencies that caused or were likely to cause serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code 1280.1(a).

Findings:

Patient 1 was admitted to the telemetry (portable heart monitor) unit on 10/02/13. Patient 1 had surgical repairs on 10/02/13 of facial fractures with nasal packing (Gauze, foam, or cotton that has been packed into the nose) and Patient 1's jaws were wired closed. Patient 1 was readmitted to the telemetry unit (portable heart monitor) post-operatively. Patient 1 was alert, oriented and Patient 1 communicated by writing, due to her jaws wired closed.

During interview on 11/05/13 at 4:00 p.m., Family Member 3 stated Patient 1 had learned how to self-suction because she had fears of choking and thought the nurses might not make it to her room in time when she needed to be suctioned, so she was doing it herself. Family Member 3 stated on 10/05/13 at 1:30 p.m., Patient 1 was having difficulty with increased secretions and was complaining of not being able to breathe very well. Family Member 3 stated Patient 1 had been self-suctioning even before her surgery, because she had difficulty swallowing and had "fears of choking." Family Member 3 stated she was worried about Patient 1 and felt there was a disconnect with Patient 1 and the nurses. Family Member 3 stated she was worried about Patient 1.

a. Mandatory TeamSTEPPS training:
   - a 4 hour class teaching an evidence-based teamwork system to improve communication and teamwork skills among health care professionals.
   - Courses facilitators / trainers included ACNP, AHA Training Center Coordinator, and Registered Nurse, Staff II from ICU.
   - Training commenced on 12/11/13 and concluded on 01/30/14 for applicable nursing staff on 2 North.

b. Mandatory education titled, "Assessment / Reassessment and Plan of Care Important Practice Reminders" includes:
   - a HealthStream (an electronic education and tracking system) module developed to review nursing practice related to patient assessment and reassessment, plan of care documentation, standards of care, and patient education.
   - emphasis on the requirement to re-assess patients as indicated by a change in the patient's level of care, diagnosis, condition, response to treatment, change in condition, as well as the patient's and/or family's needs and the care they are seeking.
   - emphasis on the need to notify the physician / allied health professional (A/P), throughout the patient's stay, in a timely manner about pertinent changes in the patient's condition utilizing SBAR (communication/hand-off report utilizing Situation, Background, Assessment, and Recommendation).
and told the nurses of her concerns before she went home that evening at 6:30 p.m. Family Member 3 stated Patient 1 was more anxious, weak, and tired and was unable to relax.

During an interview on 10/10/13 at 4:00 p.m., and on 11/06/13 at 8:00 a.m., Licensed Staff D stated that on 10/06/13 at 7:00 p.m., Patient 1 and Family Member 2 were anxious. Licensed Staff D stated that on 10/06/13 at 0:00 p.m., Patient 1 needed to be suctioned again and at that time Licensed Staff D noted a small blood clot in Patient 1's right nostril. She stated she checked the left nostril and mouth and did not see any blood (patient's jaws were wired closed). She stated Patient 1 was still anxious and complained of not being able to get the secretions out of the back of her throat. There was no documented evidence of a nursing assessment of why Patient 1 was exhibiting anxiety. The physician was not notified.

During an interview on 11/06/13 at 8:00 a.m., Licensed Staff D stated that she should have notified the physician sooner after the first small blood clot in the right nostril was noted and the wires should have been cut sooner.

During an interview on 10/10/13 at 4:00 p.m., and on 11/06/13 at 8:00 a.m., Licensed Staff D stated that on 10/06/13 around 8:30 p.m., Family Member 2 came out of the room and stated Patient 1 was having a nosebleed from the left nostril. Licensed Staff D stated when she went into the room the nosebleed had stopped and Patient 1 was still very anxious. There was no documented evidence of a
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nursing assessment of why Patient 1 was exhibiting anxiety and a nursing assessment of Patient 1's nosebleed of the left nostril. The physician was not notified.

During an interview on 11/05/13 at 1:15 p.m., Family Member 2 stated that on 10/06/13 around 10:00 p.m., Licensed Staff F helped Patient 1 to the bedside commode, and also helped Patient 1 orally suction out a 2 inch blood clot. During an interview on 10/28/13 at 4 p.m., and on 11/06/13 at 11:30 a.m., Licensed Staff F stated she informed Licensed Staff D of the nosebleed. The physician was not notified. There was no documented evidence of a nursing assessment of Patient 1's bleeding.

During an interview on 11/05/13 at 8:00 a.m., Licensed Staff D stated on 10/06/13 in the evening that she was in Patient 1's room at least every 15-30 minutes. She stated she was not too worried about Patient 1 even though Patient 1 was anxious and kept saying she was having difficulty getting the secretions out and stated she was not able to breathe. Licensed Staff D stated Patient 1's oxygen saturations were 94%-95% on room air (percentages oxygen in the blood and the normal range are 90% - 100%), skin color was good, she was talking, and her lung sounds were good. Licensed Staff D stated she was unsure why Patient 1 was so anxious.

During an interview on 11/05/13 at 1:15 p.m., Family Member 2 stated that on 10/06/13 at 11:00 p.m., Licensed Staff F helped Patient 1 to the commode.

- 1.5 hour scenario discussion, critical thinking role play, review of care of the patient with facial fracture and jaw wiring, and review of the wired jaw tool box.
- To ensure that nursing personnel obtain appropriate education, experience, and competence prior to being assigned to provide nursing care for patients with multiple/complex facial fractures including wired jaws, education on the following topics was provided and validated:
  - Patient family anxiety
  - Care of patient with nosebleed
  - Continued bleeding
  - Patient signs and symptoms including difficulty swallowing and difficult breathing
  - Documentation requirements
  - Notification to physician regarding change of patient's condition
  - Critical thinking and interpretation of patient behaviors and physiological changes as essential assessment skills.

- Successful completion of Critical Thinking and Clinical Judgment module and the Scenario / Critical Thinking and Clinical Judgment education is required. Following completion, the nursing staff's competency is validated by the ACNP noting that competency has been successfully met and can be performed independently. This competency validation is documented and placed in the employee's file.
and while she was on the commode Patient 1 began having another nosebleed. Patient 1 was put back to bed and she stated the nosebleed was "just dripping" after that. There was no documented evidence of a nursing assessment of Patient 1's bleeding.

During an interview on 10/26/13 at 4:00 p.m. and on 11/06/13 at 2:05 p.m., Licensed Staff F stated on 10/05/13 at 11:30 p.m., she was called into the room again by Licensed Staff D, who needed help. Family Member 2 and Patient 1 were very anxious. Family Member 2 wanted the physician called right away. Licensed Staff F told Licensed Staff D to call the hospitalist.

During interviews on 10/10/13 at 9:10 a.m., and on 11/07/13 at 11:00 a.m., Licensed Staff E stated that on 10/06/13 at 12:20 a.m., she saw a trickle of blood in Patient 1's mouth and a small amount in her left nostril. She stated Patient 1 was alert, very anxious, communicating, and swallowing a lot. Patient 1 told her she was having a hard time breathing. Patient 1's oxygen saturation was at 95% and Licensed Staff E stated she put her on oxygen anyway. She stated that Patient 1 was swallowing more. She stated shortly after that may be 2 or 3 minutes later Patient 1 became unresponsive, and was not breathing. Licensed Staff E stated CPR was initiated and a code blue was called.

There was no documented evidence of nursing assessments from 10/06/13 at 7:30 p.m. to 10/08/13 at 1:00 a.m., that indicated Patient 1 was...
having difficulty with increased secretions, increased anxiety, difficulty swallowing, bleeding, or trouble breathing.

During an interview on 11/06/13 at 8:00 a.m., Licensed Staff D stated she was so busy that shift she was not able to look at Patient 1's chart for physician orders, or Patient 1's history. She stated as far as the lack of documentation from 10/05/13 at 7:30 to 10/06/13 at 1:00 a.m., she stated she was so busy and everything got so hectic, that she was unable to document anything.

During an interview on 10/09/13 at 11:00 a.m., Administrative Staff C stated that Licensed Staff D had no documentation of all the events that occurred from 7:30 p.m. on 10/05/13 until Patient 1's code blue on 10/06/13 at 12:36 a.m. She stated she expected the nurses to document any change of condition and notify the physician immediately.

Review of the Hospital's policy and procedures for Nursing assessments and re-assessments, revised 11/09, indicated page 112-(p); using the nursing process, the RN will assess relevant physical, functional, psychological needs of the patient. This process begins with the RN's first encounter with the patient and is reassessed throughout the stay as conditions warrant.

Review of Clinical Nursing Skills and Techniques, 8th edition, 2010, Chapter 6, titled "Health Assessments," indicated nurses perform physical assessments on a regular basis. In an Acute Care setting the assessments are more comprehensive.
Nurses are often the first to detect changes in the patient condition. The ability to think critically and interpret patient behaviors and physiological changes are essential. The physical assessments are tools used to detect both subtle and obvious changes in a patient's health.

These failures to ensure that nursing staff provided ongoing assessments for Patient 1's change of condition for increased anxiety, airway patency, bleeding, and trouble breathing and these changes were not reported promptly to Patient 1's physician. These failures delayed the recognition of Patient 1's deteriorating medical condition that resulted in Patient 1 to bleed down the back of her throat, had a respiratory arrest and sustained an anoxic brain injury. These were violations of Section 70215(a)(1) (2) of Title 22 of the California Code of Regulations and deficiencies that caused or were likely to cause serious injury or death to the patient, and therefore constitutes an Immediate Jeopardy within the meaning of Health and Safety Code 1280.1(a).

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(e).

<table>
<thead>
<tr>
<th>ID</th>
<th>PREVIOUS SUPPLIER/CAG IDENTIFICATION NUMBER</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>060000</td>
<td>A. BUILDING</td>
<td>h. Facial Fracture Stabilization</td>
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<td>B. WING</td>
<td>i. Bedside supplies</td>
<td>1/30/14</td>
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<td>j. Secretions and suction</td>
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<td>k. Wire cutters</td>
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<td>l. Cutting Wires In an emergency</td>
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<td>4. In collaboration with the Medical Staff and Nursing, written instructions titled, &quot;How to care for a patient with a wired jaw&quot; were developed and are available to nursing staff. To ensure availability when caring for a patient with a wired jaw, a copy of these written instructions are included in the Jaw Wire Kit.</td>
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<td>5. In collaboration with the Medical Staff and Nursing, written instructions titled, &quot;Patient Care Instruction After Corrective Jaw Surgery&quot; were developed and are available to patients, family, and nursing staff.</td>
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<td>6. To ensure safe and appropriate nursing / patient care assignments, a Shift Lead Checklist was developed noting essential items that must be completed each shift by all leads / relief charge nurse on 2North nursing unit including: a. review all complex patients on unit.</td>
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<td>b. confirm that the plan of care is updated.</td>
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<td>c. confirm that staff has resources to care for patient</td>
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<td>d. confirm patient education is completed</td>
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<td>e. make assignments for oncoming shift, ensuring that staff with appropriate competencies are assigned to each patient</td>
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<td>f. Shift lead checklist is signed, dated, and presented to Department manager for review and actions if needed.</td>
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Nurses are often the first to detect changes in the patient condition. The ability to think critically and interpret patient behaviors and physiological changes are essential. The physical assessments are tools used to detect both subtle and obvious changes in a patient’s health.

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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).

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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(e).