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6/16/11

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055884	A. BUILDING _____ B. WING _____	05/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN TOMAS CONVALESCENT HOSPITAL	3560 PAYNE AVENUE, SAN JOSE, CA 95117 SANTA CLARA COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit: CLASS B CITATION -- PATIENT CARE 07-2443-0008312-S Complaint(s): CA00269214 Representing the Department of Public Health: Surveyor ID # 29260, Health Fac Evaluator Nurse The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Title 22 72311(e)(1)(C) Nursing Service-General (a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (C) Reviewing, evaluating and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition. The facility failed to update or revise a care plan for hydration with specific actions to ensure Patient 1 received the amount of daily fluids recommended by the registered dietitian (RD) when Patient 1's GT (gastrostomy tube, a tube inserted through the abdomen into the stomach through which the nursing staff provides fluid and/or liquid nutritional formula) was removed on 2/28/11 and his intake of fluids provided directly into the stomach declined.		Preparation and/or execution of this Plan of correction does not constitute admission or agreement by the provider to the truth of the facts alleged or conclusions set forth on this Statement of Deficiencies. Thsi Plan of correction is prepared/and or executed solely because of the provisions of Health and Safety Code Section 1280 and 42 CFR 483 et seq require it. This Plan of Correction constitutes our credible allegation of compliance. CORRECTIVE ACTIONS The Registered Nurse reviewed, updated and evaluated Resident 1 care plan on May 23, 2011 pertaning to risk for dehydration. The Director of Staff Development will provide 1:1 inservice to both C.N.A A and C.N.A B regarding the importance of offering fluids to residents at frequent intervals to prevent dehydration and proper implementation of care plan by June 27, 2011.	

Event ID:N8FQ11 6/15/2011 12:36:07PM

[redacted] PRESENTATIVE'S SIGNATURE TITLE Administrator (X6) DATE 06/16/2011

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	Continued From page 1 Inadequate fluid intake may put a patient at increased risk of dehydration (a condition resulting from excess loss of body fluid). Patient 1 was admitted to the facility with diagnoses including urinary tract infection, acute hemorrhagic stroke (abnormal bleeding in the brain), hemiparesis (loss of function on one side of the body) and hypertension (high blood pressure). Record review was conducted on 5/17/11 through 5/19/11. The Minimum Data Set (MDS) assessment dated 2/16/11 indicated Patient 1 was totally dependent on staff for eating, dressing, and transfers. The MDS also indicated Patient 1's ability to express ideas was severely impaired. During an observation on 5/17/11 at 11 a.m. Patient 1's water pitcher contained a small amount of liquid. The pitcher was located on an end table, which was against the wall opposite his bed. There was no drinking cup visibly located anywhere in his room. There was a note posted on the wall opposite Patient 1's bed to encourage the patient to take water. During an observation on 5/17/11 at 11:55 a.m. Patient 1 was returned to his room in his wheelchair, and positioned with his back to his end table and water pitcher, approximately two feet behind him. During an interview on 5/17/11 at 11:55 a.m. certified nurse assistant A (CNA A) stated, "I help him [Patient 1] drink his liquids and foods. He can't		Resident 1 recent urea nitrogen and soduim level dated 5/23/11 are all within normal limit. The facility attempted to udgrade fluid consistency for Resident 1 begining 5/23/11 until 6/15/11, however due to resident medical condition, the liquid upgrade failed due to risk for aspiration. The evaluation and treatment was done by Speech Pathologist. The Familiy Member is aware of the treatment outcome. Resident 1 water pitcher is being replaced twice a day prepared by the Dietary Dept. The Director of Nursing and Director of Staff Development conducted inservice to nursing staff on 6/7/2011 and on going regarding: a) Initiating, implementing updating each resident's care plan upon admission, quarterly and as needed for each change in resident"s condition. b) Dehydration which includes identification of risk factors, signs/symptoms, prevention and treatment.	

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	055864	A. BUILDING _____ B. WING _____	05/19/2011

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	Continued From page 2 take it by himself." During an interview on 5/19/11 at 7:30 a.m. CNA B stated, "I am not giving him [Patient 1] the thickened nectar water in pitcher because it's from last night. He will get another pitcher of thickened nectar water at 10 a.m. and I will give him that." During an interview on 5/17/11 at 8:30 a.m. Patient 1's family member (FM) stated getting water was a "big issue." The FM stated every time she visited Patient 1, he wanted water and drank two, 16 ounce bottles of water. She further stated the water pitcher was on Patient 1's night stand, and there was no way he could reach it. The FM stated staff wanted him to drink two pitchers of nectar-thick water. The FM stated he did not like nectar-thick water and could not reach it. The FM stated she had never seen steff offer Patient 1 water. The FM stated he got 4 oz. (ounces) nectar-thick juice and a glass of thickened milk at the most during a meal. During record review of a physician's order dated 4/15/10, it indicated flush GT with 100 cc (cubic centimeter) water flush every 6 hours. . . until 200 cc every 6 hours is attained. Patient 1's "Intake and Output Record" indicated Patient 1 received 800 cc water daily through his GT from 8/4/10 until 2/28/11 when Patient 1 pulled out his GT. "Nurses Notes" dated 2/28/11 at 12:30 a.m. indicated the licensed nurse "found the GT out and		The Interdiciplinary Team met with the Family Member on 5/17/2011 to discuss POLST (Physician Order for Life Sustaining treatment) and Resident's 1 current condition which includes food and liquid intake. The Interdisciplinary Team and/or Registered Dietitian will review all existing residents that are risk for dehydration such as residents on tube feeding, thickend liquids and risk factors for dehydration to ensure that residents are getting adequate fluids and care plan is in placed and implemented starting 6/16/2011 and on going. B. The Title or position of the person responsible for the correction: The Director of Nursing, MDS Coordinator and Interdisciplnary Team are responsible for the correction.	

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	Continued From page 3 the resident was holding it." During record review of "Tube Feeding Nutrition Assessment" dated 7/14/10, the RD indicated daily fluid needs for Patient 1 should be 2100 ml (milliliters) or 8.8 cups of fluid daily. Patient 1's "Intake and Output Record" indicated Patient 1's fluid intake by mouth ranged from 680 cc to 1250 cc daily from 2/28/11 until 4/28/11 with most days averaging less than 1000 cc by mouth daily. After the GT was removed Patient 1 did not receive the 600 ml of water through the GT and therefore was not maintaining a fluid intake of 2100 ml as the RD recommended. Patient 1's "Dietary Progress Notes" dated 8/17/10 indicated "resident on thickened liquids (nectar)" and "continues to be @ risk for dehydration." Patient 1's "Dietary Progress Notes" dated 5/2/11 indicated Patient 1 had a decline of intake by mouth and he was getting more difficult to feed. It further indicated Patient 1 disliked the nectar-thick liquids and remained at "risk for dehydration." During record review of a Progress Note dated 5/4/11, medical doctor C (MD C) indicated labs done 5/3/11 showed Patient 1's urea nitrogen (BUN - a kidney function test) was 89 (refsrence values were 7 - 20) and creatinine (also a kidney function test was 4.36 (reference value was 7 - 25). A lack of adequate hydration can cause an elevated BUN to creatinine ratio (www.webmd.com/a-to-z-guides/blood-urea-nitrogen		C. Description of the monitoring process to prevent recurrence of the deficiency: The LNs will assess residents upon admission to identify risk for dehydration, the LNs will then initiate and implement a care plan. The Medical Records will conduct a seven (7) day audit to ensure care plan is in placed. The Registered Dietitian will assess all residents upon admission, quarterly,change of condition and resident with risk for dehydration such as tube feeders, resident thickened liquid-dysphagia on monthly basis. The LNs will monitor residents during daily rounds and medpass to ensure that fluids are available,offered and within reach. The Director of NUrsing/ Designee will review at least 2 resident's charts from Monday-Friday to ensure that care plan is in placed and implemented through observation, interview and chart review.	

Event ID:N8FQ11 6/16/2011 12:36:07PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[redacted]	Admin. Nurse	6/16/2011

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	Continued From page 4). Laboratory results collected 5/5/11 at 7:15 a.m. indicated Patient 1's urea nitrogen was increased to 132 HP (normal values were 5 - 26). HP indicates high panic which is a dangerous level. Patient 1 was admitted to the acute care hospital and was diagnosed with infected ureteral stone (a kidney stone in the tube between the kidney and the bladder), and elevated sodium (an electrolyte) in the blood. Dehydration indicates the body does not have as much water and fluids as it should. Dehydration can be caused by losing too much fluid, not drinking enough water or fluids, or both (MedlinePlus - online health information). During an interview on 5/17/11 at 4:20 p.m. the RD stated after Patient 1's GT was accidently pulled out he "wasn't getting extra flushes (water) anymore - not taking in much." Patient 1's "Dehydration/Fluid Maintenance Care Plan" dated 3/13/10, indicated the care plan was not updated or revised on 2/28/11 for Patient 1's decline of intake, a loss of 800 cc's fluid through the GT, or his dislike for nectar-thick liquids he was advised to drink to meet most of his 2100 cc daily fluid needs. During an interview on 5/19/11 at 11:15 a.m. the directer of nurses (DON) stated after the "tube feeding" was discontinued on 2/28/11 she could not find an updated care plan.		The Department Heads will monitor staff to ensure that fluids and cups are w/n reached and being offered to residents, any issue of non compliance will be brought to the daily stand up meeting Monday thru Friday for resolution. D. Date the immediate correction of the deficiency will be accomplished: June 27, 2011	

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	Continued From page 5 During an interview on 5/19/11 at 11:28 a.m. the RD stated she did not have a dietary note or a care plan that addressed the loss of 800 cc's of fluid daily for Patient 1. The facility's undated policy and procedure, "Care Plan/Interdisciplinary Team" indicated "Implementation of resident's care plan is the responsibility of IDT members." The facility's undated policy and procedure, "Hydration Management" indicated "The facility is compliant if the resident was assessed for risk of dehydration, care was properly planned and implemented, outcomes evaluated and care plan revised as indicated to prevent resident from being dehydrated and to maintain optimal hydration." It further indicated "Residents identified with potential/actual dehydration will be reviewed/assessed by the IDT for attributing risk factors/conditions. These risk factors and interventions will be documented in the care plan and progress notes on the medical record." The facility failed to revise the nursing care plan to ensure Patient 1 received the daily amount of fluid recommended by the RD after his GT was removed on 2/28/11. The patient's recorded intake indicated he received about one-half of the recommended amount. Patient 1 was admitted to the acute care hospital on 5/5/11 with diagnoses including infected ureteral stone and elevated sodium in the blood. The above violation had a direct or immediate			

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Admin Asst 6/16/2011

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	Continued From page 6 relationship to the health, safety, or security of Patient 1.			6/27/11

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Administrator 6/16/2011

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