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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ E. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2012
NAME OF PROVIDER OR SUPPLIER HOLLYWOOD PRESBYTERIAN MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 N Vermont Ave, Los Angeles, CA 90027-6005 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: CA00315502 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 17030, 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 1280.1(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>(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.</p> <p>Based on record review and staff interview, the facility failed to implement its policy and procedure for "Swallow Screen for the Stroke Patient" by failing to ensure Patient A, who was assessed by a registered nurse, as not able to cough on command, not able to swallow secretions and had no swallowing reflex, was kept NPO (Nothing by Mouth) and be evaluated by a speech therapist prior to any oral intake.</p> <p>Findings:</p>			
			Actions Taken:	

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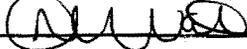
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



CNO

3/20/13

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 9

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.

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	<p>On August 13, 2012, an unannounced visit was conducted to investigate a complaint regarding the quality of care that Patient A received during hospitalization.</p> <p>A review of the Discharge Summary dated [REDACTED], 2012 disclosed Patient A presented to the emergency room of the facility with left middle cerebral artery stroke, history of Parkinson's disease, hypertension, and diabetes on [REDACTED], 2012. The patient expired on [REDACTED] 2012.</p> <p>The emergency department report dated [REDACTED], 2012 at 9:23 p.m. indicated the patient was a 72 years old female, who presented to the emergency room, with the chief of complaint of "not talking and unable to move." The physical examination by the physician indicated the patient had spasticity (stiffness/tightness) of the left side of her body, hemiparalysis (paralysis on one side of body) of the right side of the body and her lungs were clear to auscultation. The Chest X-ray completed while the patient was in the emergency room revealed the patient had normal heart and lungs and no infiltrates. The patient received aspinn medication rectally as the patient failed the swallowing test. The diagnoses in the emergency room included acute cerebrovascular accident (stroke), aphasia (unable to speak), slurred speech, generalized weakness, history of hypertension, history of diabetes and Parkinson's disease.</p>		<p>1) The Registered Nursing Staff members involved in the care of patient A were given 1:1 re-education by the Clinical Nurse Director (CND) regarding the "Swallow Screen for the Stroke Patient" policy, as well as documentation of physician response. Additionally, the involved staff members were placed in the hospitals performance management program.</p> <p>2) The "Swallow Screen for the Stroke Patient" policy was reviewed by nursing leadership (i.e. Interim CNO, Nursing Directors, etc.) and it was determined no revisions were needed.</p> <p>3) The "Swallow Screen for the Stroke Patient" policy was reviewed with the Registered Nursing staff through staff meetings and huddles by the Unit Nursing directors or qualified designee.</p> <p>4) Re-Education was provided on the "Swallow Screen for the Stroke Patient" policy and validated via a repeat back of information as well as demonstration of competency. For those requiring further instruction, this was provided immediately.</p> <p>5) Upon Registered Nurse new hire education is provided on the "Swallow Screen for the Stroke Patient" policy and validated via a repeat back of information as well as demonstration of competency. For those requiring further instruction, this was provided immediately.</p>	<p>8/31/2012</p> <p>11/2012</p> <p>3/2013</p> <p>3/27/2013</p> <p>Upon New Hire</p>

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	<p>The plan was to transfer the patient to the Telemetry unit.</p> <p>A review of the Swallow Screen Assessment Form dated [REDACTED] 2012 at 8:15 p.m., disclosed the registered nurse had assessed the patient's swallowing ability. According to the Swallow Screen Assessment form, the nurse would answer Yes or No to the 5 items on the form. Patient A was assessed as not able to "cough on command," not able to "swallow secretions," and "swallow reflex" was not present. According to the form, if the answer was No to any of the items 1 through 5, stop the screen, keep the patient as NPO (nothing by mouth) and obtain an order for Speech Therapy consultation. The form indicated the swallow screen/assessment was to be done on all stroke patients prior to any oral intake including medications.</p> <p>The Admission Assessment Report dated [REDACTED] 2012 at 1:12 a.m., indicated the patient arrived to the Telemetry unit at 11:30 p.m. on [REDACTED] 2012, with weakness and was unable to talk.</p> <p>The Physician Orders dated [REDACTED] 2012 at 12:01 a.m., indicated the patient was admitted to the telemetry unit with orders that included observation for 23 hours and a cardiac diet.</p> <p>A review of the "Daily Focus Assessment Report" dated [REDACTED] 2012 at 12:00 a.m.,</p>		<p>Compliance and Monitoring</p> <p>The Chief Nursing Officer (CNO) and/or qualified designee(s) will perform an audit of 30 charts per month to ensure completion of swallow screen for the stroke patients, with a compliance rate of 100%, for a period of three consecutive months, then re-evaluate. Corrective actions will be taken as opportunities arise. Data will be analyzed, tracked, trended and reported to the Performance Improvement/Patient Safety committee and through the Performance Improvement Process, to the Board of Governors.</p> <p>Person Responsible: Chief Nursing Officer</p>	3/2013

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	<p>disclosed the registered nurse performed a swallowing screen assessment and revealed the patient was not able to "cough on command."</p> <p>The Neurology Consultation dated [REDACTED] 2012 at 12:56 a.m., disclosed the patient had a left middle artery stroke. The patient received aspirin 325 milligram rectally. The patient failed a swallowing test. The plan was to continue her home medications and to order a cardiac diet if the patient was able to swallow after being reassessed.</p> <p>An entry in the Daily Focus Assessment Report dated [REDACTED] 2012 at 8:30 a.m., by Employee 3 (registered nurse), indicated the patient was fed, ate with good appetite, the patient was able to swallow without difficulty and there was no coughing noted, keep comfortable, will cont. (continue) to monitor." There was no documentation the Speech Therapist was consulted to evaluate the patient's swallowing ability prior to feeding the patient as indicated in the facility's policy and procedure.</p> <p>Another entry in the Daily Focus Assessment Report dated [REDACTED] 2012 at 9 a.m., indicated Employee 3 (registered nurse) tried to give morning medication to the patient and the patient pushed his hands. The patient did not want to open her mouth. Employee 3 documented "will notify MD (physician)." There was no documented evidence that the</p>			

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	<p>physician had responded to the patient refusing to take her morning medication.</p> <p>The Daily Focus Assessment Report dated [REDACTED] 2012 at 1 p.m., documented by ST (Speech Therapist), was reviewed and disclosed, "Group note: P.O feeding is not feasible or safe. Not a candidate for Swallow or Speech Eval (Evaluation) until alert/responsive."</p> <p>The Daily Focus Assessment Report dated [REDACTED], 2012 at 1 p.m., documented by a registered nurse, indicated the ST met with the family at the bedside and explained the patient was not ready for oral feeding and speech evaluation due to the patient being "deeply lethargic." The family expressed an understanding of the situation and the physician would discontinue the oral diet order. A nasogastric tube was in place for the medications.</p> <p>The Daily Focus Assessment Report dated [REDACTED] 2012 at 8:06 p.m. was reviewed and disclosed the patient was receiving oxygen at 2 liters per minutes with the nasal cannula. The oxygen saturation reading was 96%. The patient had a swallowing problem and was unable to take anything by mouth.</p> <p>The Physician Orders dated [REDACTED] 2012 at 11 p.m., disclosed a physician order to discontinue the diet and keep the patient NPO (nothing by mouth).</p>			

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	<p>The Daily Focus Assessment Report dated [REDACTED] 2012 at 1:33 a.m., was reviewed and disclosed the patient was receiving oxygen (O2) at 2 liters per minute with the nasal cannula. The oxygen saturation (O2 sat) reading was 99%. The patient's swallowing ability was assessed and the patient was still unable to cough on command and not able to swallow secretions.</p>			
	<p>A review of the Chest X-Ray report dated [REDACTED] 2012 at 10 a.m., disclosed the patient had "Interval development of right mid and lower lung zone infiltrate (excess amount of abnormal substance accumulated in those cells or tissues)."</p>			
	<p>The Daily Focus Assessment Report, dated [REDACTED] 2012 at 12:30 p.m., indicated a swallowing evaluation was performed by a speech therapist and revealed there was no oral trial given to the patient due to the patient being lethargic. The patient had dysphagia (difficulty swallowing) and was at risk for aspiration.</p>			
	<p>The Daily Focus Assessment Report, dated [REDACTED] 2012 at 8 p.m., disclosed the oxygen saturation reading was low and the patient was placed on 50% venti (ventilation) mask. The patient's lung sounds had crackles.</p>			
	<p>The Daily Focus Assessment Report dated [REDACTED] 2012 at 9 p.m. disclosed the</p>			

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	<p>patient was placed on 100% NRM (non-rebreathing mask) and the oxygen saturation reading was low at 92-93%. The physician was informed of the oxygen saturation reading of 92-93% and ordered an ABG (arterial blood gas) test.</p> <p>The Procedure Report, dated [REDACTED] 2012 at 2:06 a.m., disclosed the patient's respiratory status was evaluated due to altered level of consciousness and desaturation. The patient underwent an endotracheal intubation with preoperative and postoperative diagnoses of acute respiratory failure and possible aspiration pneumonia.</p> <p>In the Consultation Report for ventilator management and shortness of breath, dated [REDACTED] 2012, the physician documented the following "Apparently, the patient was being fed and became hypoxic, respiratory failure, and needed to be intubated last night." The physician's impressions included the patient had respiratory failure (inadequate gas exchange by the respiratory system, with the result that levels of arterial oxygen, carbon dioxide or both cannot be maintained within their normal ranges), most likely aspiration pneumonia (develops due to the entrance of foreign materials into the bronchial tree, usually oral or gastric contents (including food, saliva, or nasal secretions), right lower lobe infiltrate (the diffusion or accumulation of substances not normal to it or in amounts in excess of the normal in the right lower lobe of</p>			

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	<p>the lung), hypoxia (a pathological condition in which the body is deprived of adequate oxygen supply) secondary to above and left middle cerebral artery cerebrovascular accident (a stroke, the rapid loss of brain function).</p> <p>During a telephone interview with the Interim Chief Nursing Officer (Employee 2) on November 20, 2012 at 2:10 p.m., she stated Employee 3 had fed the patient on [REDACTED] 2012 at 8:30 a.m. According to Employee 2, Employee 3 should have not fed the patient based on the facility's policy on swallowing screen assessment.</p> <p>According to the facility's policy and procedure for "Swallow Screen for the Stroke Patient (Policy #: CMP.PC.500)" dated August 23, 2011, it was stipulated that the registered nurse would perform a swallowing assessment by answering yes or no to the following:</p> <ol style="list-style-type: none"> Patient is awake and alert Evidence of dysarthria, slurred or garbled speech Able to cough on command Able to swallow secretions (no drooling) Swallow reflex is present if Yes to the above items, the screen will continue. If No to ANY 5 items, the registered nurse will stop the Screen and would keep the patient NPO If YES to 3 or more above items, a registered nurse would proceed to Part 2 with Swallow Trial. If NO to 3 or more above items, 			

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	<p>the registered nurse would stop the swallow screen, keep the patient as NPO, and would obtain a Speech Therapy consultation. The policy stipulated that all patients diagnosed with stroke or possible stroke would have a swallowing screen performed by a trained registered nurse prior to any oral intake including food, fluids and medications. This is done early in the patient's hospitalization to prevent complications in all patients with diagnosis of stroke or possible stroke.</p> <p>The facility's failure to follow their policy and procedure for "Swallow Screen for the Stroke Patient" to ensure the patient was kept NPO (Nothing by Mouth) and be evaluated by a Speech Therapist, after the patient had been assessed as not able to "cough on command," not able to "swallow secretions," and had no "swallow reflex" present, is a deficiency that has cause or likely to cause injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1.</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>				

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