

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

*POC accepted
12/29/14 J. Schauer*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555583	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/18/2014
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NAME OF PROVIDER OR SUPPLIER MACLAY HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12831 Maclay St, Sylmar, CA 91342-4934 LOS ANGELES COUNTY
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	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit:</p> <p>CLASS AA CITATION -- PATIENT CARE 92-2051-0011080-F Complaint(s): CA00403130</p> <p>Representing the Department of Public Health: Surveyor ID # 25219, 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>483.25(j) F327 Sufficient Fluid To Maintain Hydration The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>The facility failed to ensure Resident 1 was provided sufficient fluids to prevent dehydration, including but not limited to failures to:</p> <ol style="list-style-type: none"> 1. Ensure that Resident 1, who was admitted to the facility with diagnoses of urinary tract infection (UTI), dysphagia (swallowing difficulties) and dehydration, was provided and consumed 2010 cubic centimeters (cc) of fluid as indicated in the nutritional assessment. 2. Ensure that the licensed nursing staff monitored Resident 1's hydration status by means of accurate and continuous intake and output (I&O) records, with prompt communication between nursing staff, 		<p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>Medical Records designee will initiate audits on residents who are on I & O's daily.</p> <p>New admission charts will be brought to the clinical meeting the business day following the admission to ensure that the amount of fluid calculated to meet the resident's nutritional needs is accurate.</p> <p>The Director of staff Development will audit 5 ADL flow-sheets daily to ensure that the documentation is legible and accurate.</p> <p>The DNS or designee will spot check 5 charts of residents on I&O daily to ensure that the I&O procedure is being followed accurately and will educate those individuals who need further training.</p> <p>The DNS and DSD will report of non-compliance will be reported monthly to the QA&A committee monthly for</p>	<i>9/25/14</i>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Maia Donohoe

TITLE

Executive Director

(X6) DATE

12/29/14
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By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 12

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>as indicated in the facility's policy and procedures for the prevention of dehydration.</p> <p>3. Promptly notify the physician when Resident 1's 24-hour fluid intake was not met for several days, and inquire of further medical interventions as necessary to prevent dehydration.</p> <p>These deficient practices resulted in Resident 1's hospitalization on [REDACTED] [REDACTED] 2014, at 2: 35 p.m., nine days after being admitted from the general acute care hospital (GACH 1). Resident 1 became unresponsive and was transferred via paramedics (emergency personnel) to GACH 2. She was diagnosed with hypovolemia (decreased fluid volume of the blood), dehydration (condition in which the total body fluid volume is reduced or depleted), fecal impaction (accumulation of feces in the bowel which may be caused by poor fluid consumption), and kidney failure. Resident 1 died on [REDACTED] [REDACTED], 2014, five days after she was transferred to GACH 2.</p> <p>On [REDACTED] 2014, the Department received a complaint that alleged Resident 1 was unresponsive, with fast breathing, low blood pressure, and was transferred to GACH 2 by paramedics (emergency personnel) on [REDACTED] [REDACTED], 2014.</p> <p>A review of the skilled nursing facility (SNF) admission record indicated Resident 1 was admitted from GACH 1 on [REDACTED] [REDACTED] 2014, with diagnoses that included UTI, swallowing difficulties, decreased oral intake, and a dehydration.</p>		<p>Care plan for residents with high risks of Dehydration must be specific and updated timely and accurately to the needs of the resident</p> <p>Care Plans for bowel management of resident with high risk of constipation must be reviewed and updated accurately and timely. Medical Records has been directed to add a column on the MAR under "supplements" to allow the nursing staff to document the percentage of supplements that they administer to the residents.</p> <p>The CNA's is reporting the totals of I&O for the shift to their charge nurses to ensure that the amounts documented on the ADL flow sheet and the amounts that the charge nurse administered are added accurately and documented on the I&O flow sheet.</p> <p>The licensed nurse in charge of the resident's care must report any poor fluid intake which is less than the Registered Dietitian's recommendation to primary physician immediately for further clinical intervention.</p>	9/25/14

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	<p>The discharge instructions sent with the resident to the SNF from GACH 1 indicated upon discharge, Resident 1 had diagnoses of dehydration and UTI, had to be monitored for dehydration and UTI, and needed to drink enough fluids to keep the urine clear or pale yellow in color.</p> <p>A review of the Resident 1's Dehydration Risk Assessment Tool dated [REDACTED] 2014, indicated she had a moderate risk for dehydration, and the tool indicated a plan of care was required. However, on [REDACTED] 2014, at 3: 50 p.m., during a record review and an interview, Registered Nurse 1 (RN 1) was asked to provide a plan of care to address interventions for Resident 1's risk for dehydration. RN 1 stated there was a nutritional care plan developed by the Registered Dietician (RD), but the licensed nursing staff did not develop a plan of care that included interventions to prevent dehydration.</p> <p>A review of the Registered Dietician's Nutritional Assessment dated [REDACTED] 2014, indicated Resident 1 had a height and weight of 65 inches and 149 pounds respectively. The RD's assessment also indicated the resident was confused, had swallowing difficulties and her daily fluid requirement (fluids needed to maintain proper hydration) was 2010 cc of fluid per day. There was no indication on the assessment of the resident's moderate risk for dehydration.</p> <p>There was a care plan for "Alteration in Nutrition" dated [REDACTED] 2014, that indicated to maintain adequate hydration for 3 months. The approaches</p>		<p>All those reviewed resident's plan of care of "Alteration of Fluid" were reviewed and revised accurately by DNS / Registered Dietitian.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>The Director of Nursing and the Director of Staff Development and Clinical Consultant gave in-service to the nursing staff on:</p> <p>The signs and symptoms of dehydration.</p> <p>The Assessment of Fecal Impaction.</p> <p>The Intake and Output policy, the importance of accurate intake and output documentation, and the importance of legible documentation.</p> <p>The licensed staff must be prompt to notify the physician when residents are not consuming enough fluid.</p> <p>The Stop and Watch Program has been initiated with all staff. The CNAs are now using Stop and Watch to let the licensed nurse know of resident who is not consuming enough fluid for further clinical intervention</p>	9/25/14

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	<p>included to monitor meal intake, offer/encourage fluids, and to assist/feed as needed. The care plan was not specific for dehydration and did not incorporate the [REDACTED] 2014, fluid needs assessment of 2010 cc per day, completed by the RD.</p> <p>For example, the licensed nursing staff did not incorporate interventions that indicated how the 2010 cc of fluid per day would be provided to Resident 1; there was no indication as to the responsible persons to provide the fluids, and how the resident's intake of fluids would be monitored. The care plan did not indicate alternative interventions to be taken if the resident did not consume the 2010 cc of required fluid needs as assessed by the RD.</p> <p>A review of the Minimum Data Set, a comprehensive assessment tool, dated [REDACTED] 2014, indicated the resident had long and short-term memory problems, and was totally dependent on staff for toileting, eating, and drinking.</p> <p>On [REDACTED] 2014, during an interview with Family Member 1 she stated she is a registered nurse and knew the conditions of Resident 1 when discharged from GACH 1 to the skilled nursing facility on [REDACTED] 2014. According to FM 1, Resident 1 had normal vital signs and no fever. FM 1 stated that on [REDACTED] 2014, she received a call from the facility informing her Resident 1 was transferred to GACH 2 because she was unresponsive, had a low blood pressure and fast breathing. When FM 1 arrived at GACH 2 she was informed by the</p>		<p>those indentified high risk for dehydration residents.</p> <p>If there are residents identified as not receiving adequate amounts of fluid the resident's primary physician must be notified for further clinical interventions.</p> <p>Those identified residents' bowel assessment for the any possible irregularity were done and none were found of such condition. The bowel management program has been continued with close monitoring of their daily bowel movement report from CNAs who are providing the direct ADL care to the residents.</p> <p>Those identified residents' ADLs record is being reviewed daily by RN Supervisors and Licensed Nurse in charge of their care. Any discrepancies of if any resident did not have bowel movement within 1- 2 days the clinical intervention will be done immediately until the satisfactory results recur.</p> <p>Plan of Care for the bowel management of those identified resident were reviewed and updated with accuracy.</p>	9/25/14	

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	<p>physician the resident was unresponsive and had abnormal labs. The labs were: Sodium was 176 (normal range is 135 to 145), BUN (blood urea nitrogen test shows how well the kidneys and liver are working) was 93 (normal range is 8 to 20), Creatinine 4.41 (test to show how well your kidneys work), and had dehydration and kidney failure. During the interview, FM 1 stated that in her entire career as a registered nurse, she had never seen a sodium level that high.</p> <p>The intake and output record [(I&O) a record to monitor how much liquid was consumed and eliminated as urine] initiated on [REDACTED] 2014, was reviewed with RN 1. The I&O record from [REDACTED] to [REDACTED] 2014, indicated the resident did not receive and consume 2010 cc of fluid per day in accordance with the RD's assessment. According to the I&O record Resident 1 consumed between 1050 cc and 1320 cc of fluids per day.</p> <p>For example, the intake from [REDACTED] through [REDACTED] 2014 was as follows according to documentation on the I&O sheet: [REDACTED] was 1340 cc; [REDACTED] was 1320 cc; [REDACTED] was 1080 cc; [REDACTED] was 1100 cc; [REDACTED] was 1050 cc; [REDACTED] was 1070 cc; [REDACTED] was 570 cc with no 7 a.m. to 3 p.m. intake recorded, and no 24 hour total recorded; [REDACTED] was 1120 cc; and [REDACTED] was 1170 cc. The total fluids consumed daily was recorded between 690 cc to 960 cc per day less than what Resident 1 required for her daily hydration needs according to the RD's assessment. The comment section indicated "adequate". There was no indication the physician</p>		<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies.</p> <p>This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code Section 1280 and 42 CFR 483 et seq.</p> <p>F327- Sufficient fluid to maintain hydration</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Resident #1 is no longer at this facility</p> <p>Corrective action for residents that maybe affected by this deficiency:</p> <p>DNS / DSD/ RN Supervisor and Registered Dietitian reviewed 11 residents currently on I&O and high risk for dehydration to ensure that they are receiving an adequate amount of fluid with the accurate and adequate legible documentation. The daily review of Intake and Output of those identified residents is being done by RN Supervisor and Licensed Nurse who is in charge of their care.</p> <p>Registered Dietitian also communicated and posted the recommended fluid intake for all</p>	9/25/14
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	<p>or RD had been notified of the intake.</p> <p>In addition, the I&O record under the section of Weekly Evaluations did not indicate the licensed nursing staff consistently recorded the resident's fluid output to ensure the resident's hydration status was adequate. The urine output was recorded as the number of times the resident urinated, such as 2 X, however the totals were not totaled correctly to ensure an accurate evaluation. The consistency of the urine, the color and the odor were not recorded as indicated on the discharge instruction received from GACH 1.</p> <p>On [REDACTED] [REDACTED] 2014, at 3: 50 p.m., during an interview with RN 1, she was asked why the physician was not contacted when the resident wasn't getting the required fluids necessary as assessed by the RD. RN 1 stated there was lack of documentation or communication from the certified nursing assistants indicating the resident was not drinking the required fluids. She was unable to provide the reason why the resident's I&O record was incomplete and inaccurate.</p> <p>The Medication Administration Record for [REDACTED] 2014 indicated that Isosource 250 milliliters (nutritional drink supplement) was ordered [REDACTED] 2014, to be given three times per day. It was signed off as being given, however there is no indication what amount was consumed.</p> <p>A review of the CNA - ADL Tracking Form from [REDACTED] through [REDACTED] 2014, revealed the daily documentation was illegible and inconsistent in the</p>			

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	<p>areas of "Dietary Supplement Offered" and "Fluids Offered". In the supplements area the documentation for all three shifts is either "0" or "8" meaning none or did not occur. The fluids offered and consumed was not legible for most days and did not match the I&O recording. The resident's refusal or inability to take fluids was not reported to a licensed nurse according to RN 1's statement on [REDACTED] 2014.</p> <p>The facility's policy titled, "Resident Hydration and Prevention of Dehydration" dated 2013, indicated the RD will assess all residents for hydration adequacy, nursing will assess for signs and symptoms of dehydration during daily care, nursing will monitor and document fluid intake and output in the medical record. If potential inadequate intake and/or signs and symptoms of dehydration are observed, intake and output monitoring will be incorporated into the care plan, and the physician will be notified. The RD, nursing staff, and the physician will assess factors that may be contributing to inadequate fluid intake. Orders may be written for extra fluids to be encouraged between meals. A specific minimum amount should be included, "force fluids" or "encourage fluids" are not adequate orders.</p> <p>There was no documented evidence in the clinical record that indicated the licensed nursing staff consistently monitored the resident's hydration status. This would include monitoring clinical signs and symptoms of hypovolemia /dehydration such as skin turgor (skin's ability to change shape and return to normal), dry skin, dry mucus membranes</p>			

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	<p>(moist openings such as the mouth, nose, eyes), coated tongue, irregular bowel movements and its consistency, and the urine output (color, amount, odor). Other monitoring would include consistent documentation and communication regarding the resident's refusal or inability to drink fluids, and notification of the physician to obtain alternative treatment instructions such as tube feeding and/or IV fluid replacement as indicated in the facility's undated policies and procedures (a set of principles, rules, and guidelines formulated or adopted by an organization to reach its goals) as stated above.</p> <p>On [REDACTED] [REDACTED] 2014, at 3: 50 p.m., during an interview RN 1 stated, on [REDACTED] [REDACTED], 2014, at approximately 2:30 p.m., Licensed Vocational Nurse 1 (LVN 1) called stat (a code for emergency) to the resident's room. On arrival to the room, Resident 1 was observed with excessive sweating, fast breathing, unresponsive but arousable. The vital signs were: blood pressure 99/74, pulse 76, respiration 32, and had a temperature of 102.2 taken under the arm; cooling measures were provided. Oxygen Saturation was not readable due to excessive sweating. Oxygen was given at 15 liters per minute via a non-re-breather mask.</p> <p>A review of the Licensed Nurse Progress Note dated [REDACTED] [REDACTED], 2014, at 2:30 p.m., indicated Resident 1 was diaphoretic (sweating), breathing too fast and unresponsive. The blood pressure was 99/74 (normal 120/80), temperature 102.2 degree Fahrenheit (normal 98.6°F) taken under the arm, respiration 32 breaths per minute (normal 16-20).</p>				

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	<p>The physician was notified of the resident's change of condition and an order was obtained to transfer the resident to GACH 2 via paramedics, which occurred at 2:35 p.m.</p> <p>A review of the Emergency Room Note (ER) obtained from GACH 2 dated [REDACTED], 2014, indicated upon arrival Resident 1 had an altered mental status, no pulse, a fever of 104 °F, was hypovolemic and hypotensive (low blood pressure) requiring levophed drip (medication to raise blood pressure) and CPR [cardiopulmonary resuscitation-compressing over the chest and blowing air into the lungs]. Resident 1 was intubated (insertion of breathing tube into the windpipe) and placed on a ventilator (tube connected to a breathing machine to help breath). The resident was also given 6.4 liters of IV fluid replacement (to compensate fluid loss) and two units of fresh frozen plasma, and was admitted to an intensive care unit.</p> <p>A review of the History and Physical (H&P) examination record dated [REDACTED] 2014, indicated the resident went into acute renal failure. The record indicated the x-ray of the abdomen results on [REDACTED] 2014, indicated the resident had a very large fecal impaction [a large lump of dry, hard stool that stuck in the rectum (often seen in resident's with low fluid intake and constipated for a long time)] of at least "16 by 819 centimeters."</p> <p>A review of Resident 1's laboratory test results obtained from GACH 2 dated [REDACTED], 2014, indicated the following:</p>			

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	<p>1. An elevated blood sodium level of 176 mEq/L (reference range 135-145 mEq/L). A blood sodium level of more than 150 mEq is an indicator for dehydration (American Journal of Nursing June 2006, Vol. 106 No. 6 Pages 40-49). According to the history and physical examination record dated [REDACTED] 2014, the hypernatremia (high sodium) was secondary to dehydration as the resident has been refusing on and off oral fluid intake at the SNF (skilled nursing facility). The H&P also indicated the resident had episodes of seizures secondary to high sodium.</p> <p>2. An elevated Creatinine (Cr) level of 4.41 mg/dl (reference range 0.60-1.30 mg/dL). Resident 1's BUN/Cr ratio (BUN divided by creatinine) was 26.3. [A BUN/Cr ratio of 20 to 24 is an indicator for impending dehydration and a BUN/Cr ratio of 25 and above is an indicator for dehydration ("Ranges of Laboratory Test Results for Determining Hydration Status," American Journal of Nursing June 2006, Vol. 106 No. 6 Pages 40-49)].</p> <p>BUN and Cr are waste products in the blood filtered by the kidneys and removed in the urine. The decrease blood flow to the kidneys due to reduced blood volume would affect the filtration process which in turn causes the accumulation of waste products such as BUN and Cr leading to acute renal failure, sepsis, decreased cardiac output [heart failure-cardiac arrest (AJN diagnostic clinical indicators and laboratory values May 1999- Vol. 99-Issue 5 Pages 66-69,71,73,75).</p> <p>Delayed treatment or delayed hydration may lead</p>			

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(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
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	<p>to acute renal failure a sudden decrease in kidney function that can lead to irreversible tubular necrosis (premature death or damage to the kidney cells). American Journal of Nursing May 1999 Vol. 99- issue 5 Pages 66-69.</p> <p>3. An increased white blood cell count (WBC) of 18.7 (reference range 3.6-5.1 mg/dL). An increased WBC may be an indicator for infection.</p> <p>According to GACH 2's Physician's Progress Notes and the Discharge Summary Notes dated [REDACTED] 2014, Resident 1 died on that date, the fifth day of hospitalization. The causes of death were cardiac arrest (heart failure), severe sepsis (infection), meningitis (brain infection), neuroleptic malignant syndrome (a condition where the body cannot regulate itself), and multiple organ failure (a life threatening condition when more than one body organ stops functioning).</p> <p>Based on the foregoing, the facility failed to ensure Resident 1 was provided sufficient fluids to prevent dehydration, including but not limited to failures to:</p> <p>1. Ensure that Resident 1, who was admitted to the facility with diagnoses of urinary tract infection (UTI), dysphagia (swallowing difficulties) and dehydration, was provided and consumed 2010 cubic centimeters (cc) of fluid as indicated in the nutritional assessment.</p> <p>2. Ensure that the licensed nursing staff followed monitored Resident 1's hydration status by means of accurate and continuous intake and output (I&O)</p>			
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Event ID: YU7X11

12/29/2014

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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: 555583	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/18/2014
NAME OF PROVIDER OR SUPPLIER MACLAY HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12831 Maclay St, Sylmar, CA 91342-4934 LOS ANGELES COUNTY		
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	<p>records, and prompt communication between nursing staff, as indicated in the facility's policy and procedures for the prevention of dehydration.</p> <p>3. Promptly notify the physician when Resident 1's 24-hour fluid intake was not met for several days, and inquire of further medical interventions as necessary to prevent dehydration.</p> <p>These deficient practices resulted in Resident 1's hospitalization on [REDACTED] 2014, at 2: 35 p.m., nine days after being admitted from GACH 1. Resident 1 became unresponsive and was transferred via paramedics to GACH 2. She was diagnosed with hypovolemia, dehydration, fecal impaction, and kidney failure. Resident 1 died on [REDACTED] 2014, five days after she was transferred to GACH 2.</p> <p>This violation presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result and was a direct proximate cause of the death of Resident 1.</p>				

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