

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555594	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2013
NAME OF PROVIDER OR SUPPLIER D'CONNOR HOSPITAL D/P SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 2105 Forest Ave, San Jose, CA 95128-1425 SANTA CLARA 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)
	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit:</p> <p>CLASS AA CITATION -- PATIENT CARE 07-2402-0009756-F Complaint(s): CA00338028</p> <p>Representing the Department of Public Health: Surveyor ID # 28767, surveyor</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>F323 - 483 25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>The facility failed to ensure the resident environment remained free of accident hazards for one of one sampled resident (1) when Resident 1's ventilator (a machine that provides breaths to the lungs via an artificial opening in the neck [tracheostomy]) was left in standby mode (machine remains on but delivery of air to resident and disconnect/safety alarms are suspended). Resident 1 was found unresponsive and lifesaving measures were initiated. The resident was transferred to the intensive care unit for a higher level of care. The resident expired soon after.</p>		<p>Upon identification of the use of standby mode for the resident BLS measures were initiated and a Code Blue Drill was called and resident #1 was transferred to the acute care hospital.</p> <p>Any resident using a ventilator has the potential to be affected. On a daily basis the RT staff members will check the mode for each mechanically ventilated resident.</p> <p>The respiratory therapy staff members were provided inservice education from 1/29/13 to 2/26/13 that the standby mode was not to be used in the Subacute unit. The policy has been changed effective 02/05/2013 with the following statements added. To ensure the safety of every resident who requires mechanical ventilation, the Standby Mode on a ventilator will not be utilized for any resident on the Subacute Care Unit. During respiratory care procedures the ventilator will not be powered off or placed in the standby mode.</p> <p>Once per month the Clinical Manager or her designee will make rounds on each mechanically ventilated resident to check the mode of ventilation.</p> <p>The respiratory therapy staff were re-inserviced on the facility practice of not using the Standby Mode on a Ventilator in the Subacute Unit with completion of correlating competencies. The respiratory therapy staff members will be re-educated on the facility practice of not using the Standby Mode on a Ventilator in the Subacute Unit in six months and annually and correlating competencies will be completed at that time.</p> <p>On a monthly basis the Clinical Manager or her designee will make rounds on each mechanically ventilated resident to check the mode of ventilation to ensure ongoing compliance is achieved and sustained. This information will be monitored until there are six consecutive months of 100% compliance. All information will be reported to the Unit Based PI meeting held quarterly.</p>

Event ID: I7KF11

3/4/2013

3:56:17PM

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

Sue Schuman

TITLE

Clinical Manager

(X8) DATE

3/5/13

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	<p>Continued From page 1</p> <p>Resident 1 was admitted to the facility on [REDACTED]12 with diagnoses including amyotrophic lateral sclerosis (ALS - a progressive disease that affects the brain's ability to initiate and control muscle movement, in later stages of ALS the muscles involved with breathing begin to deteriorate and the act of breathing is no longer automatic) and quadriplegia (paralysis of the arms and legs) and required mechanical ventilation (breathing by ventilator). Review of Resident 1's ventilator settings ordered by Physician 1 (PH 1) dated [REDACTED]12 indicated MODE ACVC (assist control/volume control) [ventilator provides a full breath for every breath attempted by the resident] at a Tidal Volume (size of each breath) of 450 milliliters per breath.</p> <p>On [REDACTED]13 at 10 a.m. review of Resident 1's minimum data set (MDS resident assessment and care screening form) dated [REDACTED]12 indicated Resident 1 had memory problems, and moderately impaired decision making capacity for tasks of daily life. The MDS further indicated Resident 1 was fully dependent on staff for bed mobility and activities of daily living.</p> <p>In an interview on 1/10/13 at 10 a.m., Respiratory Therapist 1 (RT 1) stated he provided care for Resident 1 since [REDACTED] admission to the facility and was familiar with the resident. RT 1 further stated although Resident 1 required mechanical ventilation [REDACTED] was able to breathe on [REDACTED] own for minutes at a time. On the morning of [REDACTED]12 at approximately 9:10 a.m. RT 1 performed tracheostomy care for Resident 1. Tracheostomy</p>			

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	<p>Continued From page 3</p> <p>emergency procedure in which the heart and lungs are made to work manually). During the emergency event, RT 1 and LVN 1 noticed the ventilator was on standby mode (machine on, but not ventilating the resident). When asked, RT 1 stated he did not recall if he placed the machine back on ventilating mode after completing Resident 1's tracheostomy care.</p> <p>In an interview on 1/10/13 at 11 a.m., LVN 1 stated that on [REDACTED] at approximately 9:15 a.m. she went into Resident 1's room to give [REDACTED] medications. Once she arrived in the room she noticed Resident 1 was unresponsive and immediately called the charge nurse and RT 1 into the resident's room for assistance. Due to Resident 1's condition a code blue (medical emergency in which a team of medical personnel work to revive an individual in cardiac arrest) was called for Resident 1. LVN 1 stated she noticed Resident 1's ventilator was on standby mode.</p> <p>On 1/10/13 at 11:15 a.m. a review was conducted of LVN 1's note dated [REDACTED] at 9:30 a.m. LVN 1 documented she "went to resident room to give morning medications at 9:25 a.m. found resident unresponsive, no pulse noted called respiratory therapy for help, called charge for help, called code blue."</p> <p>On [REDACTED] 13 at 11:30 a.m. review of Resident 1's discharge summary note dated [REDACTED] 12 by Physician 1 (PH 1) indicated the resident was transferred to the intensive care unit on [REDACTED] 12 for respiratory and cardiac arrest. The note further</p>			

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	<p>Continued From page 4</p> <p>indicated Resident 1 "had been stable in the subacute unit for several months... had been doing well on ventilator until today...Neurologically is intact". The note further indicated the resident "had a respiratory arrest as the vent was not functioning for and then went into cardiac arrest...when was noticed, was pulseless and a code blue was called."</p> <p>On 1/13 at 11:45 a.m., review of Resident 1's consultation report by Physician 2 (PH 2) dated 1/12 indicated on 1/12 "a trach change was completed but there were some complications with the ventilator after the trach change and the resident went into respiratory arrest."</p> <p>On 1/13 at 12 p.m. further review of Resident 1's medical record indicated the resident's condition worsened in the intensive care unit and Resident 1 passed away on 1/12 at 10:03 p.m.</p> <p>On 1/10/13 at 12:30 p.m. during a telephone interview with PH 1, he stated prior to the event on 1/12 Resident 1 was able to breathe on own (without the ventilator assistance) for minutes at a time. PH 1 stated he could not say for certain if the cause of Resident 1's respiratory event was due to the ventilator being left on standby mode. PH 1 further stated Resident 1's cause of death was (brain does not receive adequate oxygen), secondary to acute respiratory failure (resident's lungs do not provide adequate ventilation to the body).</p> <p>On 2/19/13 at 7:14 a.m. via a fax, the risk manager</p>			

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	<p>Continued From page 5</p> <p>indicated the facility did not have a policy and procedure regarding use of the standby mode for ventilators. According to the American Association for Respiratory Care Clinical Practice Guideline from the August 1992 issue of Respiratory Care (http://www.rcjournal.com/cpgs/mvscppg.html), MV-SC1.0 Procedure: Patient Ventilator Check, MV-SC 2.0 Description: A patient-Ventilator system check is a documented evaluation of a mechanical ventilator and of the patient's response to mechanical ventilatory support. MV-SC 2.3 All data relevant to the patient-ventilator system check must be recorded...and include observations indicative of the ventilator's operation at the time of the check. Observations should include...2.3.1 observation that the ventilator is turned on and that the patient circuit is securely attached. 2.3.2 OVP [operational verification procedure] should be performed at the bedside just prior to connection to the patient after the patient circuit has been changed or disassembled for any reason. MV-SC 4.0 Indications: ...In addition, a check should be performed 4.3 following any change in ventilator settings.</p> <p>The facility's failure to ensure the resident environment remained free of accident hazards when Resident 1's ventilator was left in standby mode after tracheostomy care presented an imminent danger to the patient and was a direct proximate cause of the death of the patient.</p>				

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