



CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050570	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <i>Corrected</i> 6/17/09 06/11/2009
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN VALLEY REGIONAL HOSPITAL & MED CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 17100 Euclid St, Fountain Valley, Ca 92708-4004 ORANGE COUNTY
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	<p><b>Continued From page 1</b></p> <p>subject to the process of competency validation for their assigned patient care unit or units. Prior to the completion of validation of the competency standards for a patient care unit, patient care assignments shall be subject to the following restrictions:</p> <p>(A) Assignments shall include only those duties and responsibilities for which competency has been validated.</p> <p>T22 DIV5 CH1 ART3 70215 Planning And Implementing Patient Care.</p> <p>(a) A registered nurse shall directly provide: (2) 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 licensure, certification, level of validated competency, and/or regulation (c) The nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, or other representatives and staff of other disciplines involved in the care of the patient.</p> <p>The above regulations were NOT MET as evidenced by:</p> <p>Based on record review and interviews, the hospital failed to implement competency standards for a licensed vocational nurse (LVN 1). The hospital failed to ensure LVN 1 was not assigned the care of</p>		<p>The Director of Surgical Services reviewed the practice of allowing outside registry nursing staff care for bariatric patients. This practice was changed, the Hospital no longer allows outside registry nursing staff to care for bariatric patients. This change was made as a result of this incident and was completed in August 2008.</p> <p><b>Training:</b></p> <p>No additional training was completed.</p> <p><b>Monitoring:</b></p> <p>The Director of Surgical Services monitored the staffing reports to assure that outside registry nursing staff did not care for bariatric patients.</p> <p><b>Responsible Person(s):</b></p> <p>The Director of Surgical Services will assure that all corrective actions noted in this plan of correction were completed.</p> <p><b>Disciplinary Action:</b></p> <p>The outside registry nurse that was involved in this incident was designated as "do not return" This action was taken in August 2008</p> <p>Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.</p> <p>Medical Staff members demonstrating non-compliance with corrective action will be referred for peer review in accordance with Medical Staff bylaws, as appropriate.</p>	<p>6/17/09 6/11/2009</p> <p>2012 APR 3 9M 3 34</p>
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Event ID:FC6Q11

3/14/2012

10:38:23AM

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

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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><b>Continued From page 3</b></p> <p>A review of the hospital's investigation of this incident, dated [REDACTED] 08, showed that temporary nursing staff (a nurse asked to work for one shift in the hospital under a contract with a staffing agency) were not to be assigned to care for bariatric patients. Bariatric patients were to be assigned to staff that have completed the bariatric competency exam.</p> <p>Review of the hospital's Nursing Services Registry/Temporary/Supplemental orientation check sheets, unit orientation forms, and competency evaluations, included care of surgical wounds and drains. LVN 1 was checked off as competent to discuss the methodology for verifying physician orders prior to implementation. The hospital was unable to provide evidence LVN 1 had a competency evaluation for care of a bariatric patient who had undergone surgery prior to being assigned to care for Patient #1.</p> <p>A clinical record review for Patient 1 began on 6/11/09. A physician's progress note dated [REDACTED] 08, showed an unplanned removal of a GT required a return to the operating room for an exploratory laparotomy under general anesthesia (incision into the abdominal wall for exploration of the abdomen). The procedure also included reinsertion of the GT. A postoperative note by the surgeon documented that on postoperative day three, she was informed by the nurse caring for Patient 1, that a nurse removed his GT. The surgeon was concerned about infection and Patient 1's complaint of pain. The surgeon performed a second surgery to ensure</p>				2012 APR 3 AM 9 35

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	<p><b>Continued From page 4</b></p> <p>there was no infection and/or contamination of the abdomen due to premature removal of the GT. There was no infection at that time.</p> <p>An interview with the supervisor of the medical/surgical units was conducted. The supervisor stated the incident for Patient 1 occurred on a weekend and LVN 1 was from a nurse staffing agency contracted with the hospital. The supervisor stated licensed nurses from temporary staffing registries have a competency check list kept in the staffing office. The competency is completed by the charge nurse. The supervisor stated LVN 1 did not have bariatric competency evaluation prior to her being assigned to care for Patient #1. The supervisor added LVN 1 was working under the direct supervision of the charge nurse.</p> <p>During interview, the charge nurse stated the incident for Patient 1 occurred on the weekend. She stated she had gone to lunch when the incident occurred. She stated she had reassigned LVN 1's patients so LVN 1 could be sent home because of declining patient census. The charge nurse stated when she returned from lunch she was surprised to see LVN 1 still at work. The charge nurse stated LVN 1 was reporting to the doctor she had pulled the GT out of Patient 1. The charge nurse stated there was no order for LVN 1 to discontinue the GT and added, "Nobody on the floor told her to do so."</p> <p>An interview with the surgeon for Patient 1 was conducted. The surgeon stated on [REDACTED] 08 she received a call from LVN 1 who stated she pulled</p>				2012 APR 3 AM 9 35

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	<p><b>Continued From page 5</b></p> <p>the gastrostomy tube out. The surgeon stated there was no order to remove the gastrostomy tube. She stated the GT was to be left in for approximately three weeks post-operatively. She stated a second surgery had to be performed to replace the GT as a preventative measure for infection for Patient 1. The surgeon stated the GT was pulled completely out. The surgeon could not remember if there were other tubes in place, but reaffirmed there was no order to discontinue the GT.</p> <p>An interview was conducted with Patient 1 on 6/17/09 at 1630 hours. Patient 1 described a meeting that took place between himself and the physician's assistant (PA). Patient 1 stated it was the third day after his surgery (08). He stated the PA told him everything looked good and he would make preparation for discharging Patient 1. He stated the PA told him the GT would be "plugged" and the urinary catheter would be discontinued. The PA then left the room. Patient 1 stated LVN 1 entered the room and discontinued the IV, the urinary catheter, and preceded to "pull" on the GT. Patient 1 stated he told the nurse he did not think removal of the GT was the plan as he had just had a meeting with the PA. He stated he told the nurse to check. The nurse left the room and returned and attempted to discontinue the GT. He told the nurse to check again and the nurse left the room. The nurse returned stating, "They told me to take the tube out." The nurse began to take the tube out and, as she did so, made the comment, "Oh No."</p>				

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	<p><b>Continued From page 6</b></p> <p>Patient 1 stated he began to bleed a lot. Patient 1 stated he was taken to surgery the same day and his hospital stay was prolonged for another week. Patient 1 stated subsequent to the second surgery he developed blood clots in his legs and was now taking medications for this (approximately one year later).</p> <p>Review of Patient 1's clinical record revealed a deep vein thrombosis of Patient 1's left leg was diagnosed on [REDACTED]08. He received treatment for this and could not be discharged from the hospital until [REDACTED]08.</p> <p>The hospital's failure to validate LVN 1's competency to care for bariatric patients who had recently undergone surgery, to provide RN supervision, and to coordinate with the physician for orders for Patient 1's care, are deficiencies that have caused, or are likely to cause, serious injury or death to the patient, and therefore constitute an immediate jeopardy within the meaning of Health and Safety Code section 1280.1(c).</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>			2012 APR 3 AM 9 35	

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