

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056169 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/24/2009 |
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| NAME OF PROVIDER OR SUPPLIER ALAMITOS WEST HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 3902 KATELLA AVENUE, LOS ALAMITOS, CA 90720 ORANGE COUNTY |
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| | <p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit.</p> <p>Representing the Department of Public Health: ██████████, HFEN</p> <p>CLASS AA CITATION -- PATIENT CARE 06-2094-0006203-S Complaint(s): CA00180633</p> <p>72311(a)(1)(A) 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: (A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission.</p> <p>72311(a)(3)(B) Nursing Service - General (a) Nursing service shall include, but not be limited to, the following: (3) Notifying the attending physician promptly of: (B) Any sudden and/or marked adverse change in signs, symptoms or behavior exhibited by a patient.</p> <p>The above regulation was NOT MET as evidenced by:</p> <p>Based on interview and clinical record review, the facility failed to conduct an assessment of Patient A's fluid needs; failed to conduct an ongoing</p> | | | |
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Event ID: RNVX11

6/9/2009

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| | <p>Continued From page 1</p> <p>assessment for signs and symptoms which could indicate insufficient fluid intake; failed to notify the physician regarding Patient A's inadequate fluid intake; and failed to evaluate intake and output records daily and weekly to identify the needs for more fluids. As a result, Patient A was admitted to the acute care hospital due to dehydration, resulting in an acute renal failure. Patient A expired in the acute care hospital 6 days later due to a cardiopulmonary arrest, dehydration, and renal failure.</p> <p>On 3/23/09, a complaint investigation was initiated regarding Patient A being transferred to the acute care hospital from a skilled nursing facility (SNF), on 12/19/08, with diagnoses of dehydration and acute renal failure.</p> <p>According to the National Institute of Health website page ; http://www.nlm.nih.gov/medlineplus/ency/article/000982.htm (website a service of the U.S. National library of Medicine and the National Institute of Health): dehydration can be caused by losing too much fluid, not drinking enough fluids, or both.</p> <p>Clinical record review began on 3/23/09.</p> <p>Review of the acute care hospital's consultation report, dated 11/19/08, that was found in the clinical record, showed Patient A, 82 year-old, was admitted to the acute care hospital from home. The patient was found at the acute care hospital to have altered mental status, dehydration, and urosepsis (infection of the urinary tract).</p> | | | |
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| | <p>Continued From page 2</p> <p>On 11/26/08, Patient A was admitted to the SNF from the acute care hospital. Patient A's admitting diagnoses included urosepsis. Patient A's admission orders included Levaquin (antibiotic) daily for urosepsis and increased white blood cell counts. The patient had an indwelling urinary catheter, which was connected to a urinary drainage bag. Patient A had normal renal functions.</p> <p>Review of a physician's order, dated 11/26/08, showed Patient A's fluid intake and urine output were to be monitored every shift.</p> <p>Review of the comprehensive care plan showed a care plan problem, dated 11/28/08, identified Patient A was at risk for dehydration. The goal was to maintain fluid volumes and electrolyte balances within normal limits. The approach specific to this goal was to encourage adequate oral fluid intake. However, there was no documented evidence in the comprehensive care plan to identify specific amounts of fluid intake Patient A needed to consume every day to prevent the patient from becoming dehydrated. There were no approaches to monitor the signs and symptoms of dehydration. Patient A had developed dehydration just prior to admission to the SNF.</p> <p>Review of a Nutritional Assessment Form, completed by the facility's registered dietician (RD), dated 11/28/08 and 12/3/08, showed documentation which noted Patient A had been dehydrated. However, there was no documented</p> | | | | |

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| | <p>Continued From page 3</p> <p>evidence the RD had assessed Patient A's daily fluid needs/requirements to ensure the patient would not again become dehydrated. Documentation on the form showed the patient was 229 pounds (104 kg).</p> <p>Review of a Laboratory Report, dated 11/29/08, (3 days after admission to the SNF), showed the resident's BUN level was 36 mg/dl (normal range: 9-23 mg/dl). The CR level was 1.0 mg/dl (normal range: 0.5 - 1.1 mg/dl).</p> <p>The initial Minimum Data Set (MDS), dated 12/5/08, showed the patient was alert with no cognitive skill impairment. The patient was assessed to require setup help for feeding and extensive assistance with one person for transfers and ambulation.</p> <p>Review of the patient's intake and output records for 12/08, showed several illegible and unreadable entries for both the intake and output. On 12/7, 12/12, 12/13 and 12/18/08, the intake and/or the output was left blank on either the night or day shift. On 12/14, 12/15, 12/16, and 12/17/08, the night shift staff documented "x2" (two times) instead of the actual amounts of urine output from the indwelling catheter.</p> <p>The legible entries, from 12/1/08 to 12/18/08, showed the patient's daily fluid intake ranged from 600 ml to 1570 ml. The fluid intake and output were not consistently totaled every 24 hours and were not evaluated every week to identify the actual daily fluid needs for Patient A.</p> | | | |
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| | <p>Continued From page 4</p> <p>Review of the Nutritional Progress Notes form, dated 12/15/08, showed the RD documented an assessment regarding a weight loss of 16 pounds since admission for Patient A. The RD documented the weight loss was secondary to fluid shifts and variable oral intake. There was no documentation pertaining to Patient A's fluid needs, or fluid intake.</p> <p>An interview with concurrent clinical record review was conducted with the RD on 3/23/09 at 1445 hours. The RD could not show a documented assessment as to Patient A's daily fluid needs. When asked to assess how much fluids Patient A would have required, the RD stated that based on the patient's metabolically active weight the patient should receive approximately 1900-2300 ml fluid per day. The RD could provide no explanation as to why Patient A's fluid intake was less than 1900-2300 ml everyday. According to the RD, the nurses should be looking to see if the patient's daily fluid intake was adequate or not and alert her if the fluid intake was not adequate. The RD could not show that this was done for Patient A. When asked if the documented intake and output were legible enough for her to read, the RD answered no, for some entries she would have to guess.</p> <p>Review of the Licensed Personnel Progress Notes, dated 11/26/08 - 12/19/08, showed on some shifts staff documented "fluids encouraged" however, there was no documentation to show the patient drank fluids when encouraged. In addition, there was no evidence in the clinical record to show staff identified that the resident was not consuming</p> | | | | |

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| | <p>Continued From page 5</p> <p>adequate fluids, despite being encouraged, nor that staff notified the physician of this.</p> <p>Review of the Licensed Personnel Progress Notes, dated 12/12/08, found documentation the patient's indwelling urinary catheter was draining dark amber urine. There was no documentation to show the physician was notified of this change. There was no documentation, prior to 12/12/08, to show the urine collecting in the drainage bag was assessed for color and clarity to know if the urine was concentrated or becoming concentrated.</p> <p>Review of the weekly License Nurse Record Summary forms, dated 12/11/08 and 12/17/08, showed a section on the summary form titled, "consistency of urine." In this section was an area to document an assessment of the color of urine; however, this area was left blank.</p> <p>An interview with concurrent clinical record review was conducted with LVN #1 on 3/23/09 at 1500 hours. According to the LVN, the treatment nurse usually assessed the urine in the indwelling urinary catheter for color, clarity, and sediment, etc. The LVN reviewed the clinical record and could not provide any documentation to show the characteristics of Patient A's urine was assessed prior to 12/12/08. The LVN could not show documentation that the physician was notified of the patient's urine being dark amber on 12/12/08. According to the LVN, the 3pm-11pm shift nurses were responsible for totaling intake and output during a 24 hour period. The LVN could not explain the reason why Patient A's intake and output were</p> | | | | |

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| | <p>Continued From page 6</p> <p>not consistently totaled. The LVN could provide no evidence to show the documented intake and output were being evaluated every week to identify the patient's fluid needs. The LVN could find no documentation in the comprehensive care plan regarding what was adequate fluid intake for Patient A. The LVN could provide no documentation to show the physician was notified regarding Patient A's low fluid intake.</p> <p>A telephone interview was conducted with Patient A's SNF primary care physician on 4/1/09 at 1500 hours. Patient A's physician stated Patient A's daily fluid needs would have been roughly about 1500- 2000 ml. When asked if the physician would have wanted to be notified if the patient consumed less than that amount, for example, 600ml, 900ml, 1100ml of fluid, the physician responded, of course. When asked if she would have wanted to be notified if the resident's urine was concentrated or dark in color, the physician stated yes.</p> <p>Review of a Laboratory Report, dated 12/18/08, showed the resident's BUN level had risen to 127 mg/dl and the Cr level had risen to 5.1 mg/dl. These two levels become elevated with dehydration.</p> <p>Review of a written statement provided by Patient A's family member revealed Patient A had complained that all food and drink tasted funny and she just could not eat, the family member informed the nurses and physician of this, but they were not concerned. Patient A had also complained of an upset stomach and nausea. Additionally, on the morning of 12/18/08, when the family member tried</p> | | | |

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| | <p>Continued From page 7</p> <p>to wake Patient A up it took 5- 6 times for the patient to awaken. The family member immediately went to the nurse and told him they needed to put Patient A back in the hospital because something was definitely wrong. The nurse informed the family member that no matter who the family member talked to they would not call the doctor. According to the family member, she was called at 0200 hours on 12/19/08, and told Patient A had been sent to the acute care hospital. When the family member arrived at the emergency room, she saw the urine in Patient A's indwelling urinary catheter drainage bag was dark brown.</p> <p>Review of the Licensed Personnel Progress Notes, dated 12/18/08 at 1300 hours, showed documentation Patient A was asleep at 1025 hours, in a deep sleep and was fully awake by 1225 hours. There was no documentation to show the physician was notified regarding the family member's concern that her mom was having trouble waking up in the morning time. There was no documentation to show the patient's urine characteristics were assessed on 12/18/08.</p> <p>The patient's clinical record confirmed that on 12/19/08, Patient A was transferred to the acute care hospital.</p> <p>Review of the acute care hospital's Emergency Room (ER) Physician Report, dated 12/19/08, showed the following: "The patient appears alert, awake, dehydrated." The ER physician's preliminary diagnoses were urosepsis, dehydration, and acute renal failure.</p> | | | | |

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| | <p>Continued From page 8</p> <p>Review of the acute care hospital's Critical Care/Pulmonology Physician Consultation report, dated 12/19/08, showed Patient A was found to have a BUN level of 130 mg/dl (normal level 9-23 mg/dl) and Cr level of 5.6 mg/dl (normal level 0.5-1.1 mg/dl). The elevated levels of BUN and Cr showed the patient was dehydrated. The physician documented the patient's renal function was apparently normal in the past. The physician documented, "the patient presents with what appears to be severe dehydration and urinary tract infection."</p> <p>Review of the renal physician's consultation report from the acute care hospital, dated 12/19/08, showed the patient had a normal Cr level of 1.0 mg/dl on 11/29/08. The physician documented Patient A's mucous membranes were extremely dry. The physician documented the impression was acute renal failure due to severe prerenal azotemia from severe volume depletion. (Prerenal azotemia: abnormal levels of nitrogen containing compounds, such as BUN and Cr, due to low volume of blood flow to the kidneys.)</p> <p>Patient A expired at the acute care hospital on 12/25/08.</p> <p>Review of the acute care hospital's final discharge report, dated 12/25/08, showed the following discharge diagnoses: 1. acute renal failure; 2. severe dehydration; 3. Leukocytosis; 4. hypertension; 5. hypocholesterolemia; 6. UTI with Candida.</p> | | | | |

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| | <p>Continued From page 9</p> <p>Review of the County of Orange Certificate of Death, completed by the physician, dated 12/31/08, showed the immediate cause of death was cardiopulmonary arrest. The other significant conditions contributing to the patient's death were dehydration and renal failure.</p> <p>The facility failed to ensure Patient A, who had a history of dehydration did not become dehydrated by failing to:</p> <ol style="list-style-type: none"> 1. Assess Patient A's fluid needs, 2. Consistently assessing the urine in Patient A's urinary drainage bags, 3. Notify the physician regarding Patient A's low fluid intake, Patient A's urine being dark amber in color on 12/12/08, and Patient A being difficult to wake up the day prior to transfer to the acute hospital, 4. Evaluate Patient A's intake and output at least weekly. <p>These violations presented either imminent danger that death or serious harm or substantial probability that death or serious physical harm to the patient would result there from and were a direct proximate cause of Patient A's death.</p> | | | |

Event ID:RNVX11

6/9/2009

11:04:13AM

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

TITLE

(X6) DATE

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.