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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:  055519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/25/2011
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NAME OF PROVIDER OR SUPPLIER <b>DOWNEY CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>13007 S. PARAMOUNT BLVD., DOWNEY, CA 90242 LOS ANGELES COUNTY</b>
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	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit.</p> <p><b>CLASS AA CITATION -- PATIENT CARE</b> 94-2336-0006718-S Complaint(s): CA00222026</p> <p>Representing the Department of Public Health: Surveyor ID # 28089, 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>72311. Nursing Service - General (a) Nursing service shall include, but not limited to, the following: (1) Planning of patient care, which shall include at least the following: (A) Identification of care needs based upon 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>On [redacted] 10, at 3:30 p.m., an unannounced visit was made to the facility to investigate a complaint regarding Patient 1, who was transferred to an acute hospital on [redacted] 10, due to a high blood sugar (glucose) level and expired on [redacted] 10.</p> <p>Based on interview and record review, the facility</p>		<p>This plan of correction constitutes the facility's written credible allegation of compliance. 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 the conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483.</p> <p><b>Identifying Prefix Tag 72311(a)(1)(A):</b></p> <p><i>Immediate corrective action(s) for those Residents affected by the deficient practice;</i></p> <p>Patient 1 was transferred to hospital</p> <p>Record review of residents with diagnosis of diabetes will be completed by 1/25/12. Residents who lack blood glucose monitoring will have physician notified and request monitoring</p> <p>Residents admitted with diagnosis of diabetes will be reviewed with physician to determine blood glucose monitoring and medication needs.</p> <p>Licensed nurses will be educated on completion of admission assessment and notification of physician of residents with diagnosis of diabetes by Regional Director of Clinical Services by 1/25/12. Licensed nurses will be educated on care plan development and implementation by Regional Director of Clinical</p>	<p>2012 JAN 25 PM 2:10 HEALTH FACILITIES INSPECTION DIVISION ADMINISTRATION 24 1/25/12 [Signature]</p>

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature]      TITLE: Administrator      (X6) DATE: 1/25/12

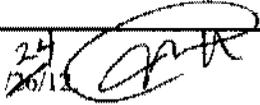
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	<p><b>Continued From page 1</b></p> <p>failed to identify Patient 1's care needs based upon a continuing assessment with input from health professionals involved in the patient's care by failing to:</p> <ol style="list-style-type: none"> <li>1. Inform the attending physician that upon readmission from an acute care hospitalization, there was no order for Patient 1 to monitor routinely the blood glucose levels, when the patient was known to the facility (had four previous admissions) to have diabetes mellitus (condition characterized by abnormally high glucose levels in the blood), used subcutaneous (SQ - under the skin) injections of insulin (medication to lower the blood glucose level), and had routine finger-stick (a device used to prick the skin and obtain drops of blood for testing) blood sugar levels checked (with the use of a glucose monitor or glucometer) at least daily.</li> <li>2. Follow up with the attending physician and the visiting Physician's Assistant (PA), to assess for the need of routine monitoring of the blood glucose levels.</li> </ol> <p>As a result, Patient 1 developed diabetic ketoacidosis (diabetic coma), became brain dead and died on [REDACTED] 10.</p> <p>According to the American Diabetes Association (www.diabetes.org/), blood sugar monitoring is the main tool to check diabetes control. The target blood glucose range in plasma before meals is from 70 to 130 milligrams per deciliters (mg/dl) and the target range after meals is less than 180 mg/dl. The American Diabetes Association further defines</p>		<p>Services by 1/26/11 </p> <p>DON/ADON/Designee will review admission records to monitor for appropriate intervention and orders for diabetes. Trending will be reported at QA &amp; A committee for appropriate action by the Administrator/Designee.</p>	
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	<p><b>Continued From page 2</b></p> <p>diabetic ketoacidosis (DKA) as a serious condition that can lead to diabetic coma (passing out for a long time) or even death. When the cells do not get the glucose they need for energy, the body begins to burn fat for energy, which produces ketones. Ketones are acids that build up in the blood when there is not enough insulin. High levels of ketones can poison the body, causing DKA. DKA can be prevented by learning the warning signs and checking urine and blood sugar levels regularly. Early warning signs are thirst or a very dry mouth, frequent urination, high blood glucose levels and high levels of ketones in the urine.</p> <p>A review of clinical record revealed Patient 1 was admitted to the facility a total of five times. The first admission to the facility was from [redacted]/09 to [redacted]/09. The patient was admitted from Acute Care Hospital 1, where she had been from [redacted]/09 to [redacted]/09, and had diagnoses of diabetes mellitus. On 5/1/09, the Attending Physician ordered blood sugar monitoring before meals and at night with Regular Insulin coverage per sliding scale (instructions for administering insulin dosages based on specific blood glucose readings). The patient was discharged home [redacted]/09.</p> <p>The second admission to facility was from [redacted]/09 to [redacted]/09. The patient was admitted from home with diagnoses of diabetes mellitus and an order for Lantus Insulin 30 units SQ every night. The patient was discharged home [redacted]/09, with the insulin order.</p> <p>The third admission to the facility was from [redacted]/09 to [redacted]/09. The patient was admitted from home with diagnoses of diabetes mellitus and</p>			

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	<p><b>Continued From page 3</b></p> <p>orders for Lantus insulin 10 units twice daily before meals, blood sugar checks twice daily before meals and to call the physician if the blood glucose was below 60 mg/dl or above 300 mg/dl. The patient was discharged home on [REDACTED]/09, with the insulin order.</p> <p>The fourth admission to the facility was from [REDACTED]/09 to [REDACTED]/09. The patient was admitted from Acute Care Hospital 1, where she had been from [REDACTED]/09 to [REDACTED]/09, had diagnoses of diabetes mellitus Type II and order for Lantus Insulin 10 units SQ daily. The patient went home [REDACTED]/09, with the insulin order.</p> <p>The fifth and last admission to the facility was from [REDACTED]/10 to [REDACTED]/10. The patient was admitted from Acute Care Hospital 1, where she had been from [REDACTED]/10 to [REDACTED]/10, due to recurrent urinary tract infection with nausea and vomiting, and dehydration. According to the transfers documents including the medication administration record (MAR) from the Acute Care Hospital 1, the patient was having blood glucose checks before meals with Regular insulin coverage per sliding scale every day of the patient's hospitalization including the day of transfer, [REDACTED]10.</p> <p>A review of the facility's admission record revealed the patient was a [REDACTED] years-old female admitted on [REDACTED]/10, at 6 p.m., with diagnoses that included diabetes mellitus, urinary tract infection, dementia and depression. The admitting orders did not include medications for diabetes mellitus (oral or SQ) and no orders to monitor blood glucose levels.</p> <p>On [REDACTED]/10, Physician's Assistant 1 (PA 1)</p>			

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	<p><b>Continued From page 4</b></p> <p>evaluated the patient and ordered blood laboratory tests, complete blood count (CBC), pre-albumin level, and basic metabolic panel (BMP). The results dated [REDACTED]/10, included glucose plasma value of 86 mg/dl with a reference range from 85 to 125 mg/dl.</p> <p>A plan of care dated 2/11/10, developed for the patient's risk for hyperglycemia (high blood glucose level) or hypoglycemia (too low blood glucose level) related to diabetes, did not have a measurable goal stated, and the interventions included to monitor finger stick blood sugar (FSBS) per physician's orders and to notify the physician of any significant results, however, there was no physician's order to perform blood sugar tests.</p> <p>The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 2/22/10, indicated the patient had short and long-term memory problems, was moderately impaired in cognitive skills for daily decision-making, required limited assistance with transfers and bed mobility, did not walk, and required extensive assistance with dressing, toilet use and personal hygiene. The patient was incontinent of both bowel and bladder functions, had diabetes mellitus disease and urinary tract infection in the last 30 days.</p> <p>Further record review revealed the Attending Physician visited the patient on 2/13/10, and PA 1 visited the patient three times, on 2/10/10, 2/16/10 and 3/4/10. However, their documentation did not address the lack of routine blood glucose testing and lack of blood glucose values after 2/11/10, to determine diabetes control.</p>			

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	<p><b>Continued From page 5</b></p> <p>A review of the nursing and interdisciplinary team notes revealed that from 2/11/10 to 3/10/11, a total of 29 days, there was no documented evidence nursing staff brought to the attention of Attending Physician and PA 1 the lack of order to routinely monitor the patient's blood glucose levels to ensure adequate blood sugar levels and prevent complications from uncontrolled diabetes.</p> <p>According to a nursing note dated [redacted]/10, timed at 9:05 a.m., the patient was noted in bed with Altered Level of Consciousness, unable to obtain vital signs and pulse oxymetry (diagnostic test that measures the amount of oxygen in a person's blood with the use of a pulse oxymeter, applied on the finger, toe, or earlobe. The device contains a sensor that is connected to a machine that displays the oxygen saturation and pulse rate), and the respiration was shallow. The blood sugar was checked and the reading was Hi (which per glucometer manual indicate a reading above 500 mg/dl). 911 (paramedics) was called. At 9:10 a.m., the paramedics arrived and transported the patient to Acute Care Hospital 1 at 9:15 a.m.</p> <p>According to Acute Care Hospital 1 Emergency Room (ER) records dated [redacted]/10, a laboratory test done at 10 a.m., revealed the blood glucose was 1,229 mg/dl. The ER Admission record indicated the ER physician documented, "The nursing home was contacted and they stated they have been unable to check the patient's blood sugars. They cannot do it unless they get a doctor's order to do it per information relayed to me by my nurse when</p>			

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	<p><b>Continued From page 6</b></p> <p>she called." The patient was placed on an endotracheal tube (breathing tube).</p> <p>The History and Physical dated [REDACTED]/10, documented in the impression diagnosis, diabetic ketoacidosis, urinary tract infection, sepsis (severe illness in which the bloodstream is overwhelmed by bacteria), Altered Level of Consciousness, acute renal failure, and diabetes mellitus.</p> <p>A Neurology Consultation dated [REDACTED]/10, documented the patient was deeply comatose clinically consistent with brain death.</p> <p>A Discharge Summary dated [REDACTED]/10 (expiration date), indicated the patient neurologically remained unresponsive throughout the course of the hospitalization, was pronounced brain dead by neurology, the finding were related to the patient's family who decided to extubate (remove the breathing tube). The patient was pronounced dead on [REDACTED]/10, at 7:55 p.m. The diagnoses included brain death, diabetic ketoacidosis, septic shock (a serious condition that occurs when an overwhelming infection leads to life-threatening low blood pressure), and urosepsis (infection ranging from urinary tract infection to generalized sepsis).</p> <p>According to the Certificate of Death, the date of death was [REDACTED]/10, at 7:55 p.m., with the cause of death indicating septic shock, urosepsis, diabetic ketoacidosis, and diabetes mellitus type II.</p> <p>On 5/5/10, at 1:20 p.m., during an interview, the Director of Nursing stated the patient was readmitted without an order for insulin and, "If the physician does not order the blood sugar to be checked we will not check it." The Director of</p>			

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	<p><b>Continued From page 7</b></p> <p>Nursing further stated that on the day the patient was transferred the blood sugar was checked because it was an emergency. The Director of Nursing explained the patient had multiple admissions to facility because the family brought her to the facility each time the patient's husband, who was the caregiver, was hospitalized.</p> <p>On 5/5/10, at 2:55 p.m., during another interview, the Director of Nursing stated both the admitting nurse and the physician are both responsible to make sure all orders are current and correct.</p> <p>On 7/25/11, at 1:30 p.m., an interview was conducted with Registered Nurse 1 (RN 1), the admitting nurse on the patient's last admission to the facility dated [redacted]/10. RN 1 stated that he knew the patient from previous admissions and that the patient was diabetic and had insulin per sliding scale, however, the transferring hospital stopped the order upon transfer. RN 1 further stated he did clarify it with the nurse (did not know the name) from the hospital but forgot to document it. RN 1 explained that the Attending Physician had two PAs working for him, PA 1 and PA 2. RN 1 faxed all the admission orders written in the transfer documents to the Attending Physician's office and if there were any changes PA 2, on duty that evening, would call him. However, no changes to the admission orders were made.</p> <p>On 7/25/11, at 2:45 p.m., during an interview with PA 2, she acknowledged being on call on the evening the patient was admitted, however, she never saw the patient. PA 2 stated she verified the</p>			

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	<p><b>Continued From page 8</b></p> <p>orders written by the acute hospital discharging physician and did not make any changes.</p> <p>Multiple attempts were made to interview Attending Physician and PA 1 but failed, since they were no longer associated with the facility or for Acute Care Hospital 1 and their telephone numbers are no longer current.</p> <p>The facility failed to identify Patient 1's care needs based upon a continuing assessment with input from health professionals involved in the patient's care by failing to:</p> <ol style="list-style-type: none"> <li>1. Inform the attending physician that upon re-admission from an acute care hospitalization, there was no order for Patient 1 to monitor routinely the blood glucose levels, when the patient was known to the facility to have diabetes mellitus, had used SQ injections of insulin, and had routine finger-stick blood sugar levels checked at least daily.</li> <li>2. Follow up with the attending physician and the visiting PA, to assess for the need of routine monitoring of the blood glucose levels.</li> </ol> <p>As a result, Patient 1 developed diabetic ketocidosis (diabetic coma), became brain dead and died on [REDACTED] 10.</p> <p>The above violation presented either imminent danger that death or serious harm would result or a substantial probability that death or serious</p>			

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DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/25/2011
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NAME OF PROVIDER OR SUPPLIER <b>DOWNEY CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>13007 S. PARAMOUNT BLVD., DOWNEY, CA 90242 LOS ANGELES COUNTY</b>
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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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	Continued From page 9 physical harm would result and was direct proximate cause of Patient 1's death.			
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Event ID: ZFSX11

1/23/2012

8:33:46AM

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.