

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2008
NAME OF PROVIDER OR SUPPLIER HANCOCK PARK REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 505 N. LA BREA AVE, LOS ANGELES, CA 90036 LOS ANGELES 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)	(X5) COMPLETE DATE
	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit:</p> <p>CLASS AA CITATION -- PATIENT CARE 94-2128-0006956-F Complaint(s): CA00150565</p> <p>Representing the Department of Public Health: [REDACTED], HFEN I</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>A Patient who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>On May 29, 2008, an unannounced visit was conducted to investigate a complaint that Patient 1's naso-gastric tube (a pliable tube inserted into the nose, through the esophagus and into the stomach in order to provide direct enteral feedings), was found in his lungs upon transfer to the emergency room of an acute hospital.</p> <p>Based on interview, and record review, the facility failed to ensure that a resident who was fed by NGT received the appropriate services and follow their policy by not:</p>			

Event ID:M1EX11

5/3/2010

2:35:49PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2008
NAME OF PROVIDER OR SUPPLIER HANCOCK PARK REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 505 N. LA BREA AVE, LOS ANGELES, CA 90036 LOS ANGELES 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)	(X5) COMPLETE DATE
	<p>Continued From page 1</p> <p>1. Ensuring and verifying correct placement of the NGT once placed and re-inserted, per the facility's policy.</p> <p>2. Ensuring and verifying the NGT placement before administering feeding and medication administration each time, as per the facility's policy.</p> <p>On May 30, 2008, during a closed record review, Resident 1's Face Sheet indicated the resident was an 84 year old male, who was admitted to the facility on March 24, 2008. His diagnoses included aftercare for a fractured hip, deep vein thrombosis, and cancer of the prostate.</p> <p>The full assessment Minimum Data Set (MDS), a standardized comprehensive assessment and care screening tool, dated April 6, 2008, indicated the resident's cognition was fully intact and he required assistance with set up only for meals. He was totally dependent on staff for bed mobility and transferring. According to the MDS, the resident had no problems with swallowing and chewing.</p> <p>A review of a physician's order, dated May 3, 2008, indicated to insert a NGT, due to Resident 1's poor nutritional intake and weight loss.</p> <p>A care plan, dated May 3, 2008, indicated the resident was at risk for aspiration secondary to enteral NGT feedings. The staff's plan of approaches included checking the NGT placement and residual feedings every shift.</p> <p>On May 30, 2008 at 9:15 a.m., a review of the</p>			

Event ID:M1EX11

5/3/2010

2:35:49PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2008
NAME OF PROVIDER OR SUPPLIER HANCOCK PARK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N. LA BREA AVE, LOS ANGELES, CA 90036 LOS ANGELES 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)	(X5) COMPLETE DATE	
	<p>Continued From page 2</p> <p>resident's Daily and Q Shift Charting, dated May 3, 2008, during the 3 p.m. to 11 p.m. shift indicated a nurse documented a NGT was inserted by a licensed nurse, tube feedings were started at 75 milliliters (ml) per hour, and aspiration precautions were observed.</p> <p>A review of the medication administration record, (MAR) indicated the licensed nurses had initialed the MAR once every eight hours on May 3, 4, 5 and 6, 2008, but there was no indication of specific times the NGT placement was verified. The documentation did not indicate what method was used to verify proper placement of the NGT. In addition, the documentation did not indicate the result of the verification of the NGT placement. The MAR also indicated the licensed nurses were to flush the nasogastric tube with 30 milliliters of water before and after medication administration. There was no documentation by the nurses that verification of the nasogastric tube placement prior to administering water or medications.</p> <p>On May 30, 2008, at 7:15 a.m., during an interview, Resident 1's family member stated she had visited the resident on the morning of May 6, 2008, and the resident's NGT she had observed the night prior, (May 5, 2008) in the resident's nose was no longer in the resident's nose. The patient's family member also stated the certified nursing assistant (CNA 1) caring for the resident told her the resident had pulled the NGT out. The family member stated when she went back to the facility later on May 6, 2008 at 7:30 p.m., the resident's NGT had been reinserted, but it was not connected to a feeding</p>				

Event ID:M1EX11

5/3/2010

2:35:49PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2008
NAME OF PROVIDER OR SUPPLIER HANCOCK PARK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N. LA BREA AVE, LOS ANGELES, CA 90036 LOS ANGELES 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)	(X5) COMPLETE DATE	
	<p>Continued From page 3</p> <p>pump.</p> <p>During an interview on May 30, 2008, at 9:05 a.m., the director of nursing (DON) stated if the staff documented "aspiration precautions observed," it meant the staff member had ensured the head of the bed was elevated and the NGT placement had been verified. The DON stated the correct tube placement was verified by injecting air into the tube, listening with a stethoscope over the abdominal area, and then checking for residuals (stomach contents) by aspirating (withdrawing) stomach contents into a large syringe and monitoring the amount before it is returned to the stomach. The DON further indicated the staff were to indicate the NGT placement verification by initialing the MAR once during the eight hour shift.</p> <p>During an observation of two medication passes on May 30, 2008, Medication Nurse 2 demonstrated how to verify the correct placement of a gastrostomy tube by injecting 10 ml. of air into a resident's gastrostomy tube, and checking for residuals prior to administering the medications via the tube. When asked if she would do anything different to verify placement of a nasogastric tube, the LVN replied verification of an NGT was done in the same way verification of a gastrostomy tube was done.</p> <p>A review of the facility's undated policy and procedure for NGT placement and removal indicated once a tube was inserted, correct placement of the tube was verified by the nurse injecting 10 ml of air into the tube while auscultating (listening with a</p>				

Event ID:M1EX11

5/3/2010

2:35:49PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2008
NAME OF PROVIDER OR SUPPLIER HANCOCK PARK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N. LA BREA AVE, LOS ANGELES, CA 90036 LOS ANGELES 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)	(X5) COMPLETE DATE	
	<p>Continued From page 4</p> <p>stethoscope) over the resident's abdominal area for a swishing sound while the air was injected. The policy indicated placement was to be verified immediately after the tube is inserted, but the policy did not address the frequency and what time the NGT placement verification was to be done when administering water and fluids.</p> <p>A review of the facility's undated policy and procedure titled, "Feeding Tube-Instilling Medication", indicated prior to administering medications via the NGT the licensed nurses were to instill 20 ml of air into the tube while auscultating over the abdominal area, check for residuals (aspiration of stomach contents using a syringe inserted in the end of the NGT), and if tube was not adequately placed, hold medication, and adjust or replace the NGT.</p> <p>On May 30, 2008 at 11:30 a.m., the DON was questioned about the lack of documentation in regards to the resident's nasogastric tube being replaced, and the DON stated, if a resident pulled the NGT out it would be documented in the nurses notes. However, a review of the resident's nurses' notes with the DON revealed there was no documentation that Resident 1 had pulled his NGT out. In addition, there was no indication in the nurses' notes that the staff had ever reinserted the resident's NGT.</p> <p>On May 30, 2008 at 2:07 p.m., during an interview and review of CNA 1's signed declaration, CNA 1 stated she remembered Resident 1's NGT being out during her morning rounds, but could not recall</p>				

Event ID:M1EX11

5/3/2010

2:35:49PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2008
NAME OF PROVIDER OR SUPPLIER HANCOCK PARK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N. LA BREA AVE, LOS ANGELES, CA 90036 LOS ANGELES 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)	(X5) COMPLETE DATE	
	<p>Continued From page 5</p> <p>the exact date.CNA 1 stated it was the same day the resident was later transferred out to the acute hospital, which was May 6, 2008. The CNA further stated she had reported the NGT being out to Medication Nurse 1.</p> <p>During an interview on May 30, 2008 at 2:10 p.m., Medication Nurse 1 stated she had no memory of Resident 1, and that CNA 1 had reported the resident's NGT was out. However, a review of the facility's staffing assignment sheets dated May 2 through May 6, 2008, indicated Medication Nurse 1 was assigned to Station B for the 7 a.m. to 3 p.m., shift, the same station the resident resided on. A review of the medication administration record (MAR) indicated Medication Nurse 1 administered the medications to Resident 1 during the 7 a.m. to 3 p.m., shift on May 2 through May 6, 2008.</p> <p>A review of the MAR revealed prior to the resident's change in condition on May 6, 2008, the last medication was administered via the NGT at 9 p.m. There was no documented evidence that proper placement of the NGT was verified prior to and after the medication was administered.</p> <p>A review of the facility's Daily "Q" (every) Shift Report, dated May 6, 2008 at 11 p.m., written by registered nurse (RN1), indicated medications were administered via the NGT. A review of the facility's Daily Q Shift report for Resident 1 revealed two different nurse's entries dated May 6, 2008. One entry, with an illegible signature, was timed 11 p.m. to 7 a.m., indicated the resident had no acute respiratory distress, was verbally responsive and</p>				

Event ID:M1EX11

5/3/2010

2:35:49PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2008
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HANCOCK PARK REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N. LA BREA AVE, LOS ANGELES, CA 90036 LOS ANGELES 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)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p>Continued From page 6</p> <p>had a feeding infusing via an intact NGT. The second nurse's entry, timed 11 p.m., was written by RN 1, indicated the resident's NGT was "placed" and "due medications given", and the continuous feeding was infusing. In an entry, at 12:15 a.m., 90 minutes later RN 1 documented the resident was unresponsive to verbal or tactile stimulation, and was observed with shallow breathing. His oxygen saturation (indicates oxygen carrying capacity of red blood cells) was 64%, and the resident's skin felt cold and clammy. RN 1 further documented the resident's blood pressure (B/P) was 78 over 50 (normal adult B/P is 120 over 80) and the paramedics were called to transport the resident to an acute hospital.</p> <p>On June 2, 2008 at 10 a.m., during an interview, RN 1 was questioned how to verify a placement of an NGT, and he stated the end of the tube should be placed in a container of water and if bubbles are observed, the tube was in the resident's lungs. RN 1 further stated he was the nursing supervisor, and Medication Nurse 3 would have verified the placement of the resident's NGT.</p> <p>During an interview on June 2, 2008 at 10:15 a.m., the DON stated the facility does not teach the staff to "do the bubble test." The DON further stated placing the end of an NGT under water and to observe for bubbles to ascertain if the NGT was in the lungs had not been an accepted practice for many years.</p> <p>During a telephone interview on June 2, 2008 at 11:07 a.m., Medication Nurse 3 stated, if she'd</p>			
--	---	--	--	--

Event ID:M1EX11

5/3/2010

2:35:49PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2008
NAME OF PROVIDER OR SUPPLIER HANCOCK PARK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N. LA BREA AVE, LOS ANGELES, CA 90036 LOS ANGELES 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)	(X5) COMPLETE DATE	
	<p>Continued From page 7</p> <p>initialed on the MAR that she'd checked placement of the NGT, then she had done so. However, when asked if she remembered Resident 1 and his transfer to an acute care hospital, she stated she did not remember the resident or "anything about it."</p> <p>A review of the facility's undated policy and procedure titled, NGT Placement, indicated NGT placement was to be verified by injecting 10 ml of air into the NGT while auscultating for a swishing sound over the resident's abdomen.</p> <p>According to an article titled "Nasogastric Intubation and Feeding," from The Encyclopedia of Nursing & Allied Health, an on-line nursing resource, the traditional methods for verifying NGT placement is to draw 10 to 20 cc of air into the syringe, place a stethoscope over the resident's stomach and quickly inject the bolus of air into the stomach. The article further indicated the most accurate way to check for NGT placement was an x-ray. In addition, the article indicated the correct placement of the NGT should be checked every 4 hours in order to decrease the possibility of nasogastric feeding complications such as regurgitation and aspiration of the feeding.</p> <p>A review of the Emergency Medical Service (EMS) report, dated May 7, 2008, indicated the paramedics were called to the facility at 12:05 a.m. According to the report, the facility's staff had conflicting reports. The EMS report indicated the resident had an NGT and audible congestion. According to the report, at 12:14 a.m. the</p>				

Event ID:M1EX11

5/3/2010

2:35:49PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2008
NAME OF PROVIDER OR SUPPLIER HANCOCK PARK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N. LA BREA AVE, LOS ANGELES, CA 90036 LOS ANGELES 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)	(X5) COMPLETE DATE	
	<p>Continued From page 8</p> <p>resident's B/P was 108/68, pulse 120, respiratory rate greater than 48 with a decreased tidal volume (lung capacity). The electrocardiogram (indicates heart's electrical conductivity) revealed sinus tachycardia (elevated heart rate), and the resident's respirations were labored with rhonchi (a coarse gurgling sound in the lungs that indicated the presence of thick fluid). Resident 1's Glasgow coma score, (GCS), (indicates level of consciousness), was 8 (normal parameter of 15). An intravenous (IV) of normal saline was started. At 12:40 a.m., the resident's B/P was 146/99, pulse 127, and respiratory rate was 52, the glasgow coma score had decreased to 7. According to "http://en.wikipedia.org/wiki/Glasgow_Coma_Scale", brain injury is classified as severe with a GCS equal to or less than 8.</p> <p>A review of the general acute care hospital's (GACH) History and Physical Report dictated by MD 1 on May 7, 2008 indicated the resident's initial chest x-ray in the emergency room revealed the tip of the NGT was found in the left main bronchus/lower lung with patchy infiltrates (indicates areas of fluid penetration into lung tissue as seen on x-ray).</p> <p>A review of the GACH's progress note dated May 7, 2008, at 12:51 a.m., indicated the resident was suctioned in the emergency room with 20 ml of thick, tan colored secretions obtained.</p> <p>A review of an Infectious Disease (ID) consultation report completed at the GACH on May 9, 2008, by Physician 2 indicated the resident had been</p>				

Event ID:M1EX11

5/3/2010

2:35:49PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2008
NAME OF PROVIDER OR SUPPLIER HANCOCK PARK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N. LA BREA AVE, LOS ANGELES, CA 90036 LOS ANGELES 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)	(X5) COMPLETE DATE	
	<p>Continued From page 9</p> <p>admitted to the hospital with a diagnosis of aspiration pneumonia. The report indicated the resident had decreased food intake in the facility and had been started on NGT feedings, but after the feeding was started the facility staff noticed the resident was gurgling with shortness of breath. Physician 2's report further stated the chest x-ray showed the tip of the feeding tube was in the left lower lobe of Resident 1's lung.</p> <p>During the resident's stay at the GACH, Resident 1 underwent two bronchoscopes (insertion of a camera on a flexible rod directly into the lungs for visualization), and received several antibiotics for treatment of pneumonia before expiring 13 days later.</p> <p>According to Medline Plus, aspiration pneumonia was an inflammation of the lungs and bronchial tubes due to breathing in a foreign material, usually food, liquids and/or secretions from the stomach. Physician 2's consultation record further revealed the resident was placed on BiPAP, a ventilation support system and admitted to the Intensive Care Unit.</p> <p>A review of Resident 1's Certificate of Death, indicated the resident expired on May 19, 2008 at 3:10 p.m., 13 days after being transferred to the hospital. The cause of death was listed as respiratory failure due to pneumonia.</p> <p>The facility failed to implement its policy and current nursing procedure to ensure and verify correct placement of the NGT in Resident 1's</p>				

Event ID:M1EX11

5/3/2010

2:35:49PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2008
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HANCOCK PARK REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N. LA BREA AVE, LOS ANGELES, CA 90036 LOS ANGELES 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)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p>Continued From page 10</p> <p>stomach to prevent infusing of the liquid feeding into the resident's lungs.</p> <p>The facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure and verify correct placement of the NGT once placed and re-inserted, per the facility's policy. 2. Ensure and verify the NGT placement before administering feeding and medication administration each time, as per the facility's policy. <p>The above violation was a direct proximate cause of death of Resident 1.</p>			
--	---	--	--	--

Event ID:M1EX11

5/3/2010

2:35:49PM

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.