

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055888	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2009
NAME OF PROVIDER OR SUPPLIER HUNTINGTON VALLEY HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8382 NEWMAN AVENUE, HUNTINGTON BEACH, CA 92647 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: [REDACTED], HFEN</p> <p>CLASS AA CITATION -- PATIENT CARE 06-2015-0006231-S Complaint(s): CA00184802</p> <p>72311(a)(1)(A) Nursing Services - 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 Services - 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>72527(a)(4) Patients' Rights (a) Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated. The facility shall establish and implement written policies and procedures which include these rights and shall make a copy</p>			

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6/9/2009

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	<p>Continued From page 1</p> <p>of these policies available to the patient and to any representative of the patient. The policies shall be accessible to the public upon request. Patients shall have the right:</p> <p>(4) To consent to or to refuse any treatment or procedure or participation in experimental research.</p> <p>The above regulations were not met as evidenced by:</p> <p>Based on interview, clinical record review, electronic record review, and document review, the facility failed to ensure that Patient A was assessed after he experienced a change in condition. The nursing staff also failed to initiate life sustaining measures for the patient as indicated in the patient's advance directives.</p> <p>Further more, the nursing staff did not notify the physician when the patient experienced a change in condition.</p> <p>Findings:</p> <p>On 4/14/09, the Department received a report from the facility involving a patient that did not receive CPR [cardiopulmonary resuscitation].</p> <p>An unannounced visit was conducted at the facility on 4/27/09.</p> <p>During an interview with the administrator on 4/27/09 at 1533 hours, it was revealed that the incident involving Patient A took place on 3/2/09. During the interview the administrator referred to the</p>			

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	<p>Continued From page 2</p> <p>investigation report that he had completed on 3/20/09. The administrator stated that he was called at his home on the evening of 3/2/09, and the receptionist informed him that Patient A had a massive cardiac arrest and that he had expired. He stated he was told that the family had been notified and that everything was okay. He stated that he did not find out that the patient's family had concerns because 911 was not called during the patient's decline, until later since the RN [registered nurse] involved (RN supervisor) had not been forthright regarding what took place at the time of the incident. He stated the RN supervisor did not call 911 when the patient's condition was declining because she thought the patient had orders to not resuscitate. He stated the RN made a mistake when she made the determination that Patient A had orders to not resuscitate. The administrator stated the RN supervisor claimed that she reviewed Patient A's clinical record and the electronic record and came to the conclusion that the patient did not want to be resuscitated so she provided comfort measures only. The administrator stated the patient's clinical record contained an Advance Directive form that showed the patient was a full code and did want life sustaining measures in an emergency situation. When the surveyor asked to speak with the nurses that were involved in the incident, the administrator stated the DON [Director of Nurses], RN supervisor and the LVN [Licensed Vocational Nurse] that were present at the time of Patient A's decline were no longer employed at the facility.</p> <p>Patient A's clinical record and electronic record</p>				

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	<p>Continued From page 3</p> <p>were reviewed on 4/27/09.</p> <p>Review of the patient's Admission Record form showed Patient A was admitted on 2/9/09, and that a family member was indicated as the responsible party.</p> <p>Review of the Advance Directive form contained a section where the "advance directive/preferred intensity desires" were located. Documentation on the form showed the responsible party had chosen the option that read, "I DO WANT C.P.R." The responsible party also chose certain treatment options that were desired; those included the right to be transferred to the acute hospital and to have oxygen for comfort. A hand written note on the bottom of the form showed verbal consent had been obtained by the patient's family member on 2/12/09.</p> <p>Review of the electronic record with the assistance of LVN #1, on 4/27/09 at 1512 hours, showed documentation of the patient's condition on 3/2/09. The following was documented in the progress notes:</p> <ul style="list-style-type: none"> - 3/2/09 at 0627 hours, Patient A was "in stable condition." - 3/2/09 at 1520 hours, the patient was alert and without signs and symptoms of distress. His breathing was unlabored/easy and comfort measures were provided. - 3/2/09 at 1710 hours, the patient complained of pain of the right shoulder and medication was given to calm the pain. 			

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	<p>Continued From page 4</p> <ul style="list-style-type: none"> - 3/2/09 at 1805 hours, the patient had an episode of vomiting with brown colored, thick, foul odored emesis. - 3/2/09 at 1825 hours, the patient was cleaned by the CNA and kept dry. The head of the bed was elevated to prevent aspiration. The physician was "informed" and a friend at the patient's bedside wanted to notify one of the patient's family members who lived out of state. The family member that had been contacted had returned the facility's call at 1838 hours and requested that the paramedics be called to evaluate the patient. - 3/2/09 at 1840 hours, 911 had been called; the paramedics had arrived and assessed the patient. The patient was intubated and CPR was started. After approximately 30 minutes the patient was non-responsive to treatment and announced dead after a long attempt of intubation and CPR. Paramedics stated the patient had a cardiac arrest. - 3/2/09 at 1930 hours, Patient A expired at 1930 hours of cardiac arrest. The RN documented that the patient's brother and the physician were informed. <p>Review of the patient's assessments showed the last assessment was documented by LVN #2 on 3/2/09 at 1517 hours. The assessment showed Patient A's mental status was unchanged, his respirations/breathing was regular at 20 breaths per minute, he presented with a moist cough that was not productive, his skin was dry and warm, and his temperature was 97.°F. There was no documentation to show that an assessment had been performed after the patient experienced a change in condition as evidenced by his vomiting</p>				

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	<p>Continued From page 5</p> <p>brown, thick, foul smelling emesis at 1805 hours.</p> <p>Review of the vital sign records showed the patient's vital signs were last obtained on 3/2/09 at 1433 hours. All of his vital signs were within normal limits at that time. The patient's blood pressure (tension exerted by the blood against the artery walls) was 137/70 mm/hg, his respirations were 20 breaths per minute, his pulse was 74 beats per minutes, and his temperature was 97.1°F. There was no documentation to show the patient's vital signs had been taken after he had experienced a change in condition at 1805 hours.</p> <p>A review of the physician's progress notes was conducted in an attempt to determine what had been reported to the physician on 3/2/09 since LVN #3 only documented "MD informed" in the progress notes, dated 3/2/09 at 1825 hours. It was not clear what had been reported to the physician. However, review of the physician's progress notes showed the last entry by the physician was dated 2/26/09.</p> <p>On 5/5/09 at 1918 hours, CNA #1 was interviewed via the telephone. CNA #1 stated Patient A died when she was helping CNA #2 to clean the patient after he vomited. CNA #1 stated when the patient was turned toward her she knew that he had died. When asked to explain what caused her to come to the conclusion that Patient A was dead, she stated that "he looked like he was dead." She further stated that when she checked, he did not have a pulse. CNA #1 stated that she told RN #1, and RN #1 told her to notify LVN #3. CNA #1 stated that LVN #3 checked the patient's pulse, and then she</p>			

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	<p>Continued From page 6</p> <p>used a stethoscope to check whether the patient was breathing. CNA #1 stated that LVN #3 confirmed that he was not breathing.</p> <p>On 5/5/09 at 1937 hours, CNA #2 was also interviewed over the phone. CNA #2 stated the charge nurse asked him to clean the patient after he had vomited. CNA #2 stated when he entered the patient's room the patient was quiet with his eyes open. The CNA also stated the patient looked uncomfortable. CNA #2 stated he asked CNA #1 to help him to clean up the patient because there was a lot of vomit. He further stated the vomit was brown and smelly. He stated that while they were cleaning the patient, CNA #1 informed him the patient died. He stated that he also checked the patient's pulse and respirations, and there were no signs of either.</p> <p>On 5/7/09, the surveyor contacted the patient's physician in regards to what was reported to him by the facility licensed nurse on 3/2/09. The physician responded via fax, on 5/11/09 indicating that he was informed of the patient's demise on 3/2/09 at 1930 hours. The physician further documented in the fax message that he did not get any call from the facility regarding the patient's condition prior to his demise.</p> <p>A copy of the paramedics report titled "Orange County EMS Prehospital Care Report" was received by the Department on 5/11/09. The report showed that when paramedics arrived at the facility on 3/2/09, the patient was found in bed covered with a sheet and CPR had not been initiated prior to</p>			

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