

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055671</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/17/2008</b>
NAME OF PROVIDER OR SUPPLIER <b>PARKVIEW HEALTHCARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1514 E. LINCOLN AVENUE, ANAHEIM, CA 92805 ORANGE 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>Representing the Department of Public Health: [REDACTED]</p> <p>CLASS AA CITATION -- PATIENT CARE 06-1242-0004791-S Complaint(s): CA00135423</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>The facility failed to ensure nursing service included a continuing assessment of Patient A. Patient A was admitted to the facility on 9/21/07, with dysphagia and a history of choking on food at another skilled facility, which required emergency intervention. On 10/12/07, Patient A choked on food, was transported to the emergency room and died later that same day.</p> <p>Patient A was admitted to the facility on 9/21/07, with diagnoses that included traumatic brain injury, diabetes mellitus, type II, aphasia (speech difficulty), dysphagia (swallowing difficulty) and right</p>			

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11/6/2008

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	<p><b>Continued From page 2</b></p> <p>food too fast."</p> <p>On 9/21/07, a plan of care was initiated to address the patient's risk for choking on food. The following was documented "monitor for possible choking or aspiration...encourage the resident to eat slowly and chew completely...hx (history) dysphagia."</p> <p>On 9/28/07 at 1510 hours, the physician ordered a "dietician consult."</p> <p>On 10/3/07, the RD (registered dietician) documented the patient's therapeutic diet, food intake and weight, as well as a recommendation to add vitamin supplements and "baseline" labs.</p> <p>On 10/3/07, the plan of care pertaining to the patient's risk for choking or aspiration was updated. The following was documented under the heading "problems/strengths." "[Patient A] is becoming an unsafe eater...he feeds himself fast and doesn't swallow before putting more food in his mouth." "C.N.A. to feed [Patient A] from now on." "C.N.A. will feed [Patient A] because he can't follow instructions."</p> <p>DSS (dietary services supervisor) notes dated 9/21/07 through 10/10/07, were reviewed.</p> <p>On 10/10/07, the DSS documented "notes as of 10/3/07, [Patient A] needs more assistance with feeding...feeds himself fast and doesn't swallow before putting more food in mouth...at this time, no choking or aspiration noted...will continue to monitor p.o (by mouth) intake."</p>				

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	<p><b>Continued From page 3</b></p> <p>On 10/12/07 at 1730 hours, the licensed nurse documented he was summoned to the patient's room by C.N.A 1. The licensed nurse documented he was told the patient "possibly choked on his food." According to the licensed nurse's documentation, C.N.A. 1 told the licensed nurse [Patient A] all of a sudden reached for part of his chopped meal while he [C.N.A. 1] was "fixing his drink." "Upon arrival at [Patient A] room, found that the C.N.A. had already removed the waist restraint from the resident and had already initiated the Heimlich maneuver."</p> <p>The licensed nurse documented he performed the Heimlich maneuver "in an effort to expel obstruction..." However, the licensed nurse was unsuccessful. "[Patient A] was already non-responsive and had no gag reflex."</p> <p>The documentation further revealed Patient A was placed on the floor, at which time C.N.A. 1 was instructed to initiate CPR (cardiopulmonary resuscitation). At that time, the licensed nurse documented he left the room to check the patient's health record. The licensed nurse documented, "saw on resident's face sheet that he was DNR (do not resuscitate) but I still had doubts about it...called resident's sister ...to confirm code status....[sister] said resident was full code, so immediately called 911 then went back to resident's room to help them with CPR."</p> <p>On 10/12/07 at 1800 hours, the licensed nurse documented Patient A was transported, via EMS</p>				

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	<p><b>Continued From page 4</b></p> <p>(emergency medical service) to the acute care hospital.</p> <p>An EMS "Prehospital Care Report" dated 10/12/07 contained the following information.</p> <p>The document listed an "alarm" time of 1738 hours. The time identified when EMS was summoned by the skilled nursing facility. EMS staff documented the "chief complaint" as "apneic airway obstruction...cardiac and respiratory arrest, duration 15 minutes." A "History of Illness/Injury" included the following statement, "witness choking while eating."</p> <p>EMS documentation included a description of the patient upon their arrival to the skilled nursing facility, "Cyanotic" (bluish skin discoloration), unconscious, totally obstructed." An "Initial Assessment" was documented as "full arrest secondary to choking."</p> <p>EMS personnel administered CPR, Heimlich maneuver, AED (automated external defibrillator) and visualization of the airway with removal of 10 cc (cubic centimeter) of "various food material." At 1750 hours, an ETT (endotracheal-breathing tube) was placed. Patient A was administered intravenous Epinephrine, times four doses, and Atropine, times three doses, in an attempt to re-start the patient's heart. CPR was "continuous" in route, as well as upon arrival to the emergency room.</p> <p>A "Cardiopulmonary Resuscitation Record" was</p>			

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	<p><b>Continued From page 5</b></p> <p>included within the acute care hospital documents. The following documentation was noted, "pre-arrest comments-found down at [skilled nursing facility], witnessed... [Patient A] intubated by [EMS personnel]...EMS states food found in throat."</p> <p>Emergency room documentation revealed CPR was stopped at 1811 hours, to check for a "rhythm." Patient A remained "asytyle" (without a heartbeat). Patient A was pronounced dead at 1811 hours. The emergency room physician documented "prolonged down time prior to arrival...further efforts futile, not prolonged...acute cardiopulmonary arrest."</p> <p>On 10/17/07, a letter was forwarded to the Department by the skilled nursing facility. Administrative nursing staff notified the Department of the 10/12/07 incident, which resulted in Patient A's death. Administrative staff documented "[Patient A] was in his room being fed by a C.N.A. when he began coughing and showed signs of choking...the C.N.A. called the Charge Nurse on duty...and witnessed the [patient] to be in distress."</p> <p>Administrative staff further documented C.N.A. 1 initiated the Heimlich maneuver while the charge nurse verified the code status. "Once code status was confirmed with the sister, 911 was called and life saving measures were initiated."</p> <p>On 1/14/08, during an interview with Patient A's sister, the following was revealed. The patient's sister stated Patient A had a previous episode of</p>			
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	<p><b>Continued From page 6</b></p> <p>choking on some strawberries at his prior facility. "He almost died....they took him to the emergency room...you could not turn your back for one second or leave food in front of him." The patient's sister stated she made the current skilled nursing facility aware of the patient's problem of grabbing food and choking.</p> <p>On 2/9/08 at 1130 hours, Patient A's sister stated on 10/12/07 at 1736 hours, the licensed nurse telephoned her and told her "[Patient A] is turning black, do you want him revived." The patient's sister stated the licensed nurse mentioned the "DNR" status; however, Patient A's sister stated "I don't know where they got that...he has never been DNR."</p> <p>On 3/17/08 at 1205 hours, a telephone interview was conducted with C.N.A. 1. The C.N.A. stated Patient A's food tray, which consisted of a burrito, was on a tray table, which was situated in front of the patient. C.N.A. 1 stated he observed Patient A grab a "big piece of burrito" as he [C.N.A. 1] fixed the patient's container of milk. C.N.A. 1 further stated Patient A's face changed from "red to purple." The C.N.A. stated he "pushed" on the patient's stomach "but nothing happened." C.N.A. 1 stated he called the nurse, who also "pushed on his stomach....but nothing happened."</p> <p>C.N.A. 1 further related the nurse placed the patient on the floor and initiated CPR. C.N.A. 1 stated the licensed nurse left the room to call 911; therefore, the C.N.A. stated he continued to perform CPR</p>				

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	<p><b>Continued From page 7</b></p> <p>until the licensed nurse re-entered the patient's room and EMS personnel arrived.</p> <p>When asked if the C.N.A. was aware Patient A had a behavior of grabbing large amounts of food at one time and choking, C.N.A. 1 stated he was not aware of the behavior. C.N.A. 1 further stated he had fed Patient A in the past and had not experienced any such behaviors.</p> <p>A "Cause of Death" was forwarded to the Department from the Coroner's Department on 2/4/08. The following was included within the document, "Aspiration of gastric contents, due to dysphagia, clinical, due to traumatic injury of brain..."</p> <p>According to the information obtained, the facility failed to provide a continuing assessment of the patient's needs with input, as necessary, from health professionals involved in Patient A's care. The facility failed to ensure Patient A received consistent supervision during a meal and failed to ensure Patient A received prompt emergency medical care, as stipulated on the facility's "face sheet" and advanced directive document.</p> <p>These facility failures were a direct proximate cause of death to the patient or resident of the long-term health care facility.</p>				

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