

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>05E119</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/20/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>TUSTIN CARE CENTER, INC.</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1051 BRYAN AVENUE, TUSTIN, CA 92780 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], Evaluator</p> <p>CLASS AA CITATION -- PATIENT CARE 06-1779-0006323-S Complaint(s): CA00181842</p> <p>73311(a) Nursing Service - General</p> <p>Nursing service shall include, but not limited to, the following: (a) Identification of problems and development of an individual plan of care for each patient based upon initial and continuing assessment of the patient's needs by the nursing staff and other health care professionals. The plan shall be reviewed and revised as needed but not less often than quarterly.</p> <p>The facility failed to ensure nursing care included a continuing assessment of Patient A. On 3/16/09, the facility reported to the Department Patient A had choked during lunch provided by the facility on 3/14/09; Patient A choked on food provided to him by the facility. Patient A had been declining physically. There was no documented evidence the facility assessed Patient A's ability to tolerate and manipulate the consistency of the diet provided to him during the decline.</p> <p>Findings:  On 4/20/09 at 1330 hours, an unannounced visit</p>			

Event ID:88QF11

7/27/2009

1:48:52PM

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

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	<p><b>Continued From page 1</b></p> <p>was made to the facility in response to the self reported unusual occurrence.</p> <p>On 4/20/09, review of the health record for Patient A was initiated. The health record showed Patient A was admitted to the facility on 10/27/08, with diagnoses of hypertension, lung mass, status post CABG (coronary artery bypass graft), ASHD (arteriosclerotic heart disease) and hyperlipidemia (high cholesterol).</p> <p>The nurse's admission record dated 10/27/08, showed Patient A had both upper and lower dentures. He was alert, continent, ambulatory and able to feed him self.</p> <p>A care plan problem dated 10/27/08, addressed alteration in oral/dental status. One of the approaches was to monitor the patient's diet tolerance.</p> <p>A dietary note dated 11/23/08, showed Patient A was independent with eating and needed limited assistance with meals. Patient A had had a regular diet ordered.</p> <p>There was no mention of an assessment by dietary or by the Interdisciplinary Team (IDT) of Patient A's swallowing ability or the patient's ability to safely tolerate a regular diet consistency.</p> <p>Patient A was readmitted to the facility on 2/3/09, with the additional diagnoses of generalized weakness. The physician ordered a regular diet for Patient A upon admission. The "Preferred Intensity</p>				

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	<p><b>Continued From page 2</b></p> <p>of Care" form dated 2/3/09, showed Patient A to be on full code status. A form titled "Patient Self-Determination Act of 1990" dated 2/3/09, showed the form was signed by a family member. The reason given was "the resident is too weak."</p> <p>Documentation in the social service notes dated 2/9/09, showed the "resident seems to be getting weaker these days and is having a harder time moving around."</p> <p>The IDT note dated 2/9/09, showed Patient A was to eat meals under supervision; there would be close observation of the Patient's condition. However, there was no continued assessment of Patient A's ability to manage the consistency of the diet provided to him during his functional decline.</p> <p>Review of a RAP (Resident Assessment Protocol) problem dated 2/9/09, to address nutritional status showed the nature of the problem was triggered by the need for a therapeutic diet with supplemental feeding secondary to inadequate intake. Complications and risk factors were identified as at risk for weight fluctuations secondary to variable food intake, secondary to anemia, renal insufficiency and generalized weakness. The decision to develop a care plan was due to the need to follow up on the patient's weight, laboratory data, skin status and hydration.</p> <p>Review of the social serves notes dated 2/10/09, showed Patient A was incontinent of bowel and bladder with difficulty breathing and preferred to lie down and was out of the bed for meals only.</p>				

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	<p><b>Continued From page 3</b></p> <p>The IDT notes dated 3/2/09, showed Patient A had a change in condition with a decline in activities of daily living. In addition, the IDT notes showed Patient A had a decline in mobility due to a weight gain of five pounds within a month. However, there was no assessment data supporting this statement. Nor were there any assessments for other possible indications for Patient A's decline.</p> <p>Review of the care plan failed to show the facility reviewed and revised the plan of care to address the resident's decline/change of condition.</p> <p>A licensed nurse's note dated 3/14/09, showed Patient A was verbally responsive, without shortness of breath, and needed extensive assistance with activities of daily living. Patient A was generally weak, unable to ambulate by himself and to continue to monitor the patient. At 1200 hours, the licensed nurse documented, Patient A was sent to the dining room in a wheelchair for lunch. He ate 20 percent of his lunch, which consisted of Korean soup with rice. At 1230 hours, Patient A experienced difficulty breathing; the CNA summoned the licensed nurse and performed the Heimlich maneuver. The licensed nurse placed the patient on the floor and initiated CPR and called 911. Patient A was then transferred to the acute care hospital.</p> <p>On 4/20/09 at 1335 hours, during an interview with the Director of Nursing (DON), when asked the location of Patient A, she stated the patient had expired.</p>			

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	<p><b>Continued From page 4</b></p> <p>On 4/20/09 at 1400 hours, in an interview with the DON, she stated the patient had experienced weight loss and the facility was attempting to help the patient with his weight loss problems.</p> <p>On 4/20/09 at 1450 hours, in an interview with the CNA, she stated on 3/14/09 at 1200 hours, she observed Patient A in the dining room eating lunch with his wife; who is also a patient in the facility. Patient A's wife beckoned for her. She noticed the patient was slumped over and limp. The CNA called for the licensed nurse and initiated the Heimlich maneuver. The CNA further stated Patient A was very lethargic the day of the incident. She noticed Patient A's decline and knew he was very ill.</p> <p>During an interview with the DON on 4/20/09 at 1500 hours, when asked if there was additional dietary assessment information, the DON stated there was no additional dietary information.</p> <p>On 4/20/09 at 1600 hours, in a telephone interview with the licensed nurse, she stated the CNA alerted her to Patient A and informed her he could not talk. The CNA was unable to dislodge the food using the Heimlich maneuver. The licensed nurse placed the patient on the floor and began cardiopulmonary resuscitation (CPR). She called 911 and the physician while other staff remained with the patient. Patient A did not have a pulse and did not regain consciousness. She stated the patient was weak and had been declining for weeks.</p> <p>On 4/21/09 at 0915 hours, an unannounced visit</p>				

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	<p><b>Continued From page 5</b></p> <p>was made to the acute care hospital. Review of the health record was initiated at this time.</p> <p>The Pre Hospital Care Report initiated by the Orange County Emergency Medical Services stated Patient A was flaccid and pale when they arrived. The patient also had a partially obstructed airway, absent breath signs, absent circulation and was in asystole (no heart beat). ALS (advanced life support) was implemented and a cardiac rhythm was captured.</p> <p>The health record showed Patient A arrived at the acute care hospital on 3/14/09 at 1313 hours, in full arrest. Attempts to resuscitate the patient were made. Patient A subsequently expired the same day at 1840 hours.</p> <p>Review of the Corner's Autopsy Report dated 4/7/09, showed a solid bolus of food was present in the trachea up to the bifurcation site (where the trachea splits into the two bronchia). Some of the food completely blocked the trachea lumen. The cause of death listed on the report was asphyxia due to choking on a food bolus. The report also stated there was no tumor in the patient's lungs or mass in the lumen parenchyma.</p> <p>The facility's failure to provide an ongoing assessment of Patient A's functional level and failure to assess his ability to tolerate a regular diet consistency once he continued to decline was a direct proximate cause of death for Patient A.</p>				

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