

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2010
NAME OF PROVIDER OR SUPPLIER VICTORIA HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 340 VICTORIA STREET, COSTA MESA, CA 92627 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>CLASS AA CITATION -- PATIENT CARE 06-2094-0007811-S Complaint(s): CA00244031, CA00244031</p> <p>Representing the Department of Public Health: Surveyor ID # 25717, 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(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>72311(a)(3)(B) Nursing Service - 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>			

Event ID:IQ8T11

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	<p>Continued From page 1</p> <p>72523(a) Patient Care Policies and Procedures (a) Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved.</p> <p>The facility failed to comply with the regulations as evidence by: 1) Patient A was not assessed by a Registered Nurse (RN) after Patient A had a change in condition involving his abdomen on 9/8/10; 2) The facility's Policy and Procedure (P&P), "Change of Condition Reporting," was not implemented when Patient A had a change of condition, involving his abdomen on 9/8/10; 3) Patient A's physician was not notified of Patient A's change in conditions. Patient A was found unresponsive on 9/13/10, and died on 9/13/10 from a ruptured duodenal ulcer with acute peritonitis and septic complications.</p> <p>Findings:</p> <p>On 9/29/10, medical record review was initiated for Patient A.</p> <p>Patient A was a 92 year old male who was living at home with a caregiver when he fell and broke his hip. Patient A was admitted to the facility from an acute care hospital on 8/18/10 to recover and rehabilitate from the surgically repaired broken hip. Patient A had no history of peptic ulcer disease.</p>			
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	<p>Continued From page 2</p> <p>On 9/13/10 at 1945 hours, Patient A was found nonresponsive and without a pulse. Patient A was transferred to the ED in full arrest and died at 2025 hours.</p> <p>Review of the Coroner's autopsy report showed Patient A died from a ruptured duodenal ulcer, one-inch in length; acute peritonitis with purulent accumulation within the abdominal cavity, with abdominal distention; and septic complications. The coroner stated in his report, "his untimely death was primarily due to septic complications (acute peritonitis) of his perforated ulcer."</p> <p>When an ulcer is located in the first part of the small intestines (duodenum) it is called a duodenal ulcer. If the ulcer erodes all the way through the lining of the duodenum, it is called a perforated duodenal ulcer and is a medical emergency. When an ulcer perforates, foreign contaminants flood into the peritoneal cavity (double sided lining of the stomach). An inflammation of the peritoneal cavity (peritonitis) is caused by bacteria and can result in infection of the bloodstream (sepsis) and severe illness. Symptoms of a perforated duodenal ulcer include abdominal pain, abdominal distention, low urine output, feeling sick and decreased appetite.</p> <p>On 10/1/10 at 1510 hours, an interview was conducted with the Coroner who performed Patient A's autopsy. The Coroner stated Patient A died from a ruptured duodenal ulcer</p>			
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	<p>Continued From page 3</p> <p>and resulting peritonitis and sepsis. According to the Coroner, Patient A's abdomen was full of puss and murky grey fluid. The Coroner stated the duodenal ulcer ruptured approximately one week to 3-4 days prior to Patient A being found unresponsive.</p> <p>Review of the Physician's History and Physical Assessment form completed by the Nurse Practitioner dated 8/19/10, showed a documented assessment of the patient's abdomen: Patient A had bowel sounds in all four abdominal quadrants and his abdomen was soft and non-tender.</p> <p>Review of the physician's' orders dated 8/18/10, showed an order for an "in and out" catheter to be inserted as needed if Patient A has no urinary output for six hours. This order was initiated at the acute care hospital and continued by the facility. (An "in and out" catheterization is when a narrow flexible tube is inserted into the urethra and up into the bladder to drain urine when the bladder is not emptying normally.)</p> <p>During interview with a charge nurse (Licensed Vocational Nurse - LVN 1) on 9/29/10 at 1515 hours, LVN 1 stated Patient A had no problems urinating.</p> <p>Documentation by LVN 2 dated 9/8/10 at 0300 hours (five days prior to Patient A dying), showed Patient A was restless and complaining of abdominal pain. Patient A's abdomen was</p>			
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	<p>Continued From page 4</p> <p>"hard, distended, tender to the touch." A sedative medication (Xanax), laxative medication, and pain medication were given. An "in and out" catheterization was performed; 200 cc yellow urine was obtained with only slight relief noted. The patient was assisted to the toilet and had a large bowel movement. Patient A verbalized relief and did not complain further of abdominal pain and went back to sleep.</p> <p>There was no documentation showing LVN 2 asked the RN on duty to evaluate and assess Patient A's abdomen or documentation to show the Physician was notified of Patient A's abdomen being hard, distended and tender to the touch.</p> <p>Review of the Medication Administration Record (MAR) showed Patient A was given Xanax (anti-anxiety, sedative/hypnotic medication) and Tylenol #3 (contains codeine, an opioid) at 2230 hours on 9/7/10 for pain at a level of "6" on a scale of 1 to 10 (1 = no pain; 10 = excruciating pain). Patient A had also received sleeping medication (Ambien 5 mg) on 9/7/10 at 2100 hours, as well as Seroquel 25 mg (Seroquel is an antipsychotic medication which has a side effect of sedation.)</p> <p>The next Licensed nurses' entry was dated 9/8/10 at 1230 hours, showed no documented evidence of an abdominal assessment (i.e., feeling the stomach area for tenderness, distention, or hardness; listening with a</p>				

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	<p>Continued From page 5</p> <p>stethoscope against all four quadrants of the abdomen for the absence of bowel sounds).</p> <p>Review of the facility's P&P, Change of Condition Reporting, showed it was the facility's policy that all changes in resident condition be communicated to the physician: Any sudden or serious change in a patient's condition, manifested by a marked change in physical or mental behavior, will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. For routine medical change in condition, all symptoms and unusual signs will be communicated to the physician promptly. Routine changes are a minor change in physical and mental behavior, abnormal laboratory and X-ray results that are not life threatening. The patient's change in condition and response is to be documented in the nurses' progress notes, on 24-hour report form, and the patient's care plan is to be updated. The licensed nurse responsible for the patient will continue assessment and documentation every shift for at least 72 hours or until condition has stabilized.</p> <p>Interview with concurrent medical record review was conducted with RN 1 on 10/12/10 at 1600 hours. RN 1 stated for any patients with a change in condition, the LVN should get an RN immediately to assess the patient. RN 1 was asked to review the above-described nurse's entry dated 9/8/10 at 0300 hours. RN 1 stated yes, this would be considered a change in</p>			

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	<p>Continued From page 6</p> <p>condition and the RN should have been notified and an abdominal assessment should be done by the RN and bowel sounds checked. RN 1 stated an RN should assess so that pertinent information can be obtained and relayed to the physician because maybe the patient needs to be sent out to the hospital.</p> <p>On 10/12/10 at 1630 hours, a follow-up interview with medical record review was conducted with RN 1. RN 1 stated a Change of Condition form alerts oncoming nurses to monitor the condition change and is critical that whatever the change in condition is, it is followed up upon and monitored for a period of time. The RN stated the change of condition assessment and monitoring is documented in the nurses' notes. RN 1 stated the documented abdominal problems on 9/8/10 at 0300 hours, should have been followed-up on with a change of condition assessments. When asked to review the subsequent nurses' notes for any change of condition assessment documentation, the RN showed one entry by an LVN dated 9/9/10 at 2100 hours, "voiding well, no bladder distention noted."</p> <p>During an interview on 10/12/10 at 1510 hours, Physician 1 was asked if he was called and notified of Patient A having abdominal pain with a hard, distended, tender to touch abdomen on 9/8/10. Physician 1 stated he could not remember and he may have been off-call on 9/8/10. The physician called LVN 4 over and asked the LVN if the nurses had notified him of</p>				

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	<p>Continued From page 7</p> <p>this. LVN responded, he had notified Physician 1's office nurse that the patient was having trouble urinating.</p> <p>On 10/12/10 at 1535 hours, a follow-up interview and concurrent review of the nurse's entry dated 9/8/10 at 0300 hours was conducted with Physician 1. Physician 1 was asked if based on reading the above-described nurse's note, would he have wanted the nursing staff to thoroughly and continually assess Patient A's abdomen to ensure an acute abdominal occurrence was not happening. Physician 1 stated yes, that would be his expectation.</p> <p>Further review of the subsequent nurses' notes after 9/8/10, showed there was no consistent or thorough abdominal assessments documented for Patient A. The Daily and Every Shift Charting form dated 9/10/10 at 1030 hours and 9/13/10 at 0200 hours, showed a box next to, "bowel sounds normal," was checked off. This documentation was completed by an LVN.</p> <p>A telephone interview was conducted with LVN 2 on 10/13/10 at 0710 hours. LVN 2's documentation dated 9/8/10 at 0300 hours was reviewed with her. When asked if she had notified the physician of Patient A's change in condition, the LVN stated, no, she did not because the patient was not complaining of pain after her interventions. When asked if she had notified her RN supervisor to assess</p>			
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	<p>Continued From page 8</p> <p>Patient A's abdomen, the LVN stated no, she did not. When asked if she had initiated a change in condition report, the LVN stated she could not remember and thought they were monitoring the patient for urinary retention.</p> <p>During and interview with CNA 1 (Certified Nurse Assistant) on 10/12/10 at 1640 hours, the CNA was asked if she had noticed anything different about Patient A in the few days leading up to him passing away. The CNA stated she noticed the patient was more tired, did not get out of bed as much, and was eating and drinking, "very little." When asked how the patient was urinating, the CNA stated the patient was urinating very little. The CNA stated Patient A did not use the urinal and only sometimes wanted to get up to go to the bathroom. The CNA stated the patient's incontinence briefs were mostly dry. The CNA stated the last few days the patient mostly stayed in bed with his eyes closed.</p> <p>Review of an Intake and Output Record form, showed the nurse(s) were documenting Patient A was drinking either exactly 800 or 1000 cc per shift from 9/9/10 to 9/12/10 on both the day and the evening shift, and drank 500 cc on the day shift on 9/13/10.</p> <p>Review of the documented meal percentage intakes showed on 9/12/10, the patient ate 80% of breakfast; 30% of lunch; and 25% of dinner. On 9/13/10, Patient A ate 30% of breakfast; 10% or lunch; and 25% of dinner.</p>			

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	<p>Continued From page 9</p> <p>Prior to this, documentation showed Patient A usually ate 50-60% to 80-100% of meals.</p> <p>Review of Daily and Shift Charting form dated 9/13/10 at 1800 hours, showed documentation by LVN 3, "noted with abdominal distention, in and out cath done and obtained 10 cc of yellow urine output as ordered every 6 hours will continue to monitor." At 1945 hours, documentation showed Patient A was found nonresponsive and a "code blue" was called. There was no documentation showing the physician was notified of Patient A's abdomen being distended with only 10 cc of urine output via "in and out" catheterization.</p> <p>Review of the September 2010 Treatment Administration Record (TAR) on 9/13/10, showed Patient A's urine output, prior to the 10 cc of urine at 1800 hours, was at 1200 hours. The documented output at 1200 hours, via "in and out" catheterization was unclear and was either 10 cc or 100 cc. Patient A's Intake and Output form showed an illegible squiggle mark as the urine output for the 7am - 3pm shift on 9/13/10, the 3pm-11pm shift was left blank (A normally functioning kidney should produces at least 30 cc of urine per hour. Kidneys can begin to shut down with sepsis. Sepsis is a serious body-wide response to bacteria in the blood or another infection.)</p> <p>On 10/1/10 at 1555 hours, a telephone interview was conducted with LVN 3. The LVN stated that during the last two days Patient A</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2010
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NAME OF PROVIDER OR SUPPLIER VICTORIA HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 340 VICTORIA STREET, COSTA MESA, CA 92627 ORANGE COUNTY
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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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	<p>Continued From page 10</p> <p>was not voiding well. The LVN stated she inserted an in and out catheter on 9/13/10 at 1800 hours and got out only 10cc of urine. The LVN stated the day shift (7am-3pm) on 9/13/10, had reported to her at change of shift, they had only gotten 10cc of urine on the day shift as well. When asked if this was reported to the physician, LVN 3 responded she had not, and could not remember if the prior shift had.</p> <p>Review of the nurses' notes dated 9/13/10 at 1000 hours, showed Patient A was complaining of dysuria (difficulty urinating). The documentation showed LVN 2 spoke with Physician 1's office nurse regarding this and obtained an order for a urinalysis.</p> <p>On 10/12/10 at 1610 hours, an interview was conducted with OT 1 (Occupational Therapist). OT 1 stated on 9/13/10, Patient A had completed a physical therapy session in the morning with the Physical Therapist, but when OT 1 went to get the patient for his occupational therapy session, the patient could not do any occupational therapy because of abdominal pain. The OT stated Patient A told her, "no, honey, I don't feel good, my stomach hurts." OT 1 stated the patient had never complained of abdominal pain to her before. OT 1 stated she reported this to the nurse.</p> <p>Review of a written statement from Patient A's family member, showed the family had visited on 9/13/10 and noticed Patient A was lethargic</p>			
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Event ID:IQ8T11

2/11/2011

10:27:26AM

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.

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	<p>Continued From page 11</p> <p>and his abdomen was distended. The family reported this to the nurse.</p> <p>These violations, jointly, separately or in any combination, presented either an imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result, and were a direct proximate cause of death of the patient.</p>			
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