

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B.W NG	(X3) DATE SURVEY COMPLETED C 06/07/2007
	050578		

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER KING, JR- HARBOR HOSPIT	12021 S WILMINGTON AVE LOS ANGELES, CA 90059

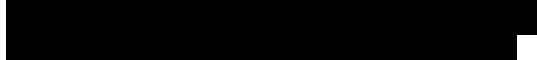
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A 0001 Initial Comment

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The following reflects the findings of the Department of Health Services during an investigation of complaint # CA00118694.

Representing the Department of Health Services:



A01211280.1(a) HSC Section 1280

A012

If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars (\$25,000) per violation.

A 0141 1280.1 (c) HSC Section 1280

A 014

For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.

DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY.

Licensing and Certification Division

TITLE (X6) DATE

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

6899

RZNI11

If continuation sheet 1 of 1

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E 6921 T22 DIV5 CH 1 ART6-70411 Basic Emergency Medical Service, Physician on	I E 692
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Basic emergency medical service, physician on duty, means the provision of emergency medical care in a specifically designated area of the hospital which is staffed and equipped at all times to provide prompt care for any patient presenting urgent medical problems.

This Statute is not met as evidenced by:

E18991 T22 DIV5 CH1 ART7-70701 (a)(4) Governing Body	E1899
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(a) The governing body shall:
(4) Provide appropriate physical resources and personnel required to meet the needs of the patients and shall participate in planning to meet the health needs of the community.

This Statute is not met as evidenced by:
The above Regulation was NOT MET as evidenced by:

Based on interview and record review, the hospital failed to ensure specialty consultation by a physician, on-going medical evaluation, medically stabilizing treatment, and physician intervention to ensure a prompt transfer to a higher level of care for Patient A when he came to the hospital for evaluation of an emergency medical condition. The governing body failed to ensure prompt correction of problems identified with appropriate physical and personnel resources for prompt transfer of patients after

Licensing and Certification Division

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E1899

review of the care provided to Patient A.

Patient A presented to the ED (emergency department) on 2/28/07 at 0950 hours, complaining of headache (comes and goes) with occasional nausea. At the time of triage, 1003 hours, the patient described that he was experiencing severe pain (10 on a scale of one to 10). The patient described that the pain was located at the back of his head and that it was relieved by vomiting.

At 1250 hours, Patient A was taken to the treatment area. Nursing assessment at that time revealed "steady gait," pupil sizes of 33 and 31 mm. A Glasgow Coma Scale score of 15 was recorded (a standardized series of observations reflecting speech, pain, orientation and speech. A score of 15 is normal).

Patient A was assessed by the emergency department physician, at which time "paras pinal tenderness" was noted, but no "Neuro" changes or "Psych" abnormalities recorded. A blood count revealed 16.4 gms. hemoglobin and a white count of 10,800 (upper normal range). Morphine 4 mg was administered in the emergency department, however, the results of the medication administration was not recorded. A CT head scan was ordered by the ED physician.

At 1550 hours Patient A was taken to CT. The report revealed, "significant ventricular dilatation with periventricular changes consistent with subependymal edema. This may be related to a heterogeneous mass near the region of the pineal with caudal extension to a level near the proximal fourth ventricle." The scan revealed a brain tumor measuring approximately 2.5 em. compressing the internal circulation of fluid in the

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brain resulting in internal swelling from dilatation of the ventricular system of the brain. An MRI image of the brain was recommended and completed. This confirmed the presence of a tumor mass in the region of the pineal gland. Moderate dilatation of the ventricular system of the brain was noted.

A handwritten note by the ED physician noted that Neurosurgery was not available at the hospital, "will arrange MAC transfer". (The MAC is the medical alert center for Los Angeles County. This is the central clearing house for all Los Angeles County hospitals.) However, there was no written documentation that physician to physician contact had been initiated to provide for a prompt transfer of Patient A to a hospital with neurosurgical services. A clinical impression of "Acute Obstructive Hydrocephalus" was recorded. A physician order for a neurosurgery consult was written at 1653 hours on 2/28/07. Orders for stabilizing medical treatment were not written.

A "Neurology Consultation" handwritten by a Physician Assistant (PA-C) identified that the patient was seen for evaluation at 1720 hours. The consultation revealed no neurological defects or alteration in mental status for Patient A. The consult described symptoms of dizziness, nausea, headache and vomiting. The consultation, provided by the PA-C, was then countersigned by the attending neurology physician at 1900 hours. No written note was provided by the neurology physician. The medical record failed to contain documented evidence that the neurologist had actually examined Patient A. This finding was in violation of the Medical Staff rules and regulations requiring a written note. The consultation request

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form revealed that "Stat MAC transfer to a facility with neurosurgical service" was required. Orders for stabilizing medical treatment were not written.

A written order for "MAC transfer to Neurosurgical facility was provided at 1717 hours by the attending ED physician. There was, however, no written documentation that any physician had actually spoken with or discussed the emergent clinical situation of Patient A with a proposed receiving hospital to facilitate transfer for Patient A. Documents contained in the medical record revealed that Patient A signed a consent form for the transfer on 2/28/07.

At 0350 hours on 3/1/07, nursing notes revealed that Patient A was administered Dilaudid (narcotic pain medication) by IVP (intravenously push). There was no documented re-assessment of Patient A by a physician. There was no documented evidence attempts were being made to find the patient a neurosurgeon and/or hospital with neurosurgical services available. A nursing re-assessment performed at 0550 hours revealed that a neurological check had been performed and the headache pain of Patient A had improved. No further physician assessments were documented. No attempts to find a hospital to assume his care and transfer were documented.

Patient A remained in the ED until 3/3/07. Review of the medical record revealed that the patient was assessed by nursing staff and continued to received Dilaudid and morphine to control his headache pain. The nursing pain assessments included only a numerical score to identify the intensity of pain but failed to identify pain radiation, quality (ache, throb, sharp, dull and/or burning) and constancy as required by

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established hospital policy. The medical record failed to provide documented evidence that ED physicians provided on-going medical assessments and stabilizing care. Except for the initial consult, the neurology PA-C or physician did not see the patient again.

On 3/3/07 at 0725 hours, nursing documentation identified that Patient A complained of occipital headache pain. The intensity of pain was recorded as 5/10. The documentation stated Patient A complained of blurred vision when ambulating. The patient was not evaluated for the neurological symptom by a physician.

At 1100 hours, Patient A complained of increased head pain. The patient identified the intensity of pain as being 9/10 (severe). The patient received Dilaudid 1 mg. IV for pain. Although a physician order was obtained for the pain medication, the patient's medical record failed to contain documented evidence that the ED physician evaluated the patient.

At 1150 hours, the patient and his family indicated that after three days, they were tired of waiting for transfer to another hospital. Patient A signed out AMA (against medical advise) to seek treatment elsewhere. The "Leaving Hospital against Medical Advice" form was noted to be incomplete. In addition, the medical record failed to contain documented evidence that at the time of discharge, the patient had been assessed by a physician or had received discharge instructions.

On 6/1/07 and 6/5/07 discussions with hospital staff regarding the care of Patient A and quality assurance, identified that the medical care received by Patient A was deemed to be appropriate. The hospital was requested to

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provide any and all documentation related to the patient's care as well as any quality of care reviews.

A case review summary for Patient A was received at 1340 hours on 6/5/07. The case review confirmed a failure of the ED physicians to document assessments of Patient A for three days. Patient A was a pending transfer to a higher level of care on 3/3/07 prior to leaving the hospital against medical advice. Further review of the case summary identified that there was a county hospital system-wide plan to provide neurosurgical services and to streamline the transfer process of patients between hospitals. As of 6/7/07, the plan had not been implemented.

The violation(s) has caused or is likely to cause, serious injury or death to the patient(s).