CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050350	A. BUILDING B. WING	01/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEVERLY HOSPITAL	309 W Beverly Blvd, Montebello, CA 90640-4308 LOS ANGELES COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00340949 - Substantiated Representing the Department of Public Health: Surveyor ID # 25524, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.1(c): 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. T22 Div5 CH1 ART3-70213 © Nursing Service Policies and Procedures (c) Policies and procedures which contain competency standards for staff performance in the delivery of patient care shall be established, implemented, and updated as needed for each nursing unit, including standards for the application of restraints. Standards shall include the elements of competency validation for patient care personnel other than registered nurses as set forth in Section 70016, and the elements of competency validation for registered nurses as set forth in Section 70016.1. At least annually, patient care personnel shall receive a written performance evaluation. The evaluation shall include, but is not limited to,		The plan of correction is prepared in compliance with regulations and is intended as Beverly Hospital's plan to address and correct any deficiencies sited. The submission of the plan of correction is not an admission by the hospital that it agrees that the citations are correct or that it violated the law. **T22 Div5 CH1 ART3-70213 (c)** Responsible Persons: Nursing Directors of Critical Care, Medical / Surgical, Emergency Care Center and Education Manager Staff meetings were conducted and included Nasogastric Tube (NGT) insertion, Competency Validation – Insertion of NGT, followed by a Post Test Competency Validation for all licensed staff in attendance. Presently 70% completed by nursing in the following areas: Critical Care, Acute Care Service and Emergency Care Center (ECC). Monitoring process: Monthly, the above nursing areas will randomly audit 50 % of orientees – Orientation Competency, at 90 days to ensure competency effectiveness/validation for six (6) consecutive months (2 Qs) and findings reported to Quality Council.	02/2014 03/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cindy Beasley TITLE: Exec. VP. Operations (X6) DATE: 12/19/14

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 9

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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	measuring individual performance against established competency standards. Based on record review and interview, the facility failed to ensure its policy and procedure on competency assessment for staff performance for naso-gastric (NG) insertion was implemented. Employee 1 a registered nurse, had an orientation competency assessment which indicated the employee had "minimal experience," "needed review," and "supervision" when performing a naso-gastric (NG) tube insertion procedure. There was no documentation that Employee 1 was competent and could perform the procedure without supervision as indicated in the facility's competency assessment. Employee 1 attempted to insert a naso-gastric tube five (5) times into Patient 1's nose. As a result, Patient 1 had intermittent bleeding and blood clots from his nose and required two surgeries to stop the nose bleeding. Findings: On May 8, 2013, an unannounced visit at the facility was conducted to investigate a complaint, regarding a nurse, who had five unsuccessful attempts of trying to insert a feeding tube causing the patient to bleed through his nose. The face sheet indicated Patient 1 was admitted to the facility on [redacted] 2012, with diagnoses that included altered mental status and hypoxia (reduction of oxygen supply to a tissue). Patient 1 was on Lovenox (an anticoagulant which affects the		Responsible Persons: Nursing Directors of Critical Care, Medical / Surgical, Emergency Care Center and Education Manager A process review/competency assessment is being conducted with the objective of updating the current nursing competency. The present competency topics are being assessed/ revised to ensure that skills listed include: high risk, low volume, and problem prone; thereby simplifying the remediation process. The Education Department will work with nursing directors to assist with competency verification by reviewing requirements for their specialty area. Also review critical elements, with the purpose of developing in conjunction with the above measurable performance criteria. The Orientation Competency Assessment is being revised to include a remediation plan to address an individual's assessment/skill need when competency assessment is below facility expectations.	02/2014 02/2014

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	blood's ability to clot and can lead to excessive bleeding "hemorrhage") medication. The Registered Nurse Admission Assessment dated [redacted] 2012 at 4:14 a.m., disclosed Patient 1 was able to follow simple commands, his speech was mumbled, and had a productive cough. The patient required assistance with feeding and had no difficulty with chewing and swallowing. A review of a Physician's Telephone Order Sheet dated [redacted] 2012, at 10:20 a.m., disclosed if the patient was alert enough and able to swallow, don't insert naso-gastric tube (NG, is a special tube that carries food and medicine to the stomach through the nose). However, if not, insert NG tube. Another Physician's Telephone Order Sheet dated [redacted] 2012, at 11:38 a.m., (1 hour and 18 minutes later), disclosed insert NG tube and start patient on Nephro formula at 20 cc (cubic centiliter)/hour. There was no documentation in the Nurses Notes by the licensed nurse, on [redacted] 2012, at 7:52 p.m., if the patient was unable to swallow, prior to inserting the NG tube. A review of an Operative Report dated [redacted] 2012 (the correct date of the operative report was [redacted] 2012 and verified with the director quality risk management on January 13, 2014, at 11:43 a.m.), disclosed the procedure performed was Endoscopic Control of Right Nasal Hemorrhage (bleeding) under general anesthesia. The finding was Right Sphenopalatine artery bleed (an artery with origin in the maxillary artery, with		Responsible Persons: Nursing Directors of Critical Care, Telemetry Medical / Surgical, Emergency Care Center and Education Manager Staff meetings consisted of the following: a process for patient swallow screening was developed and consisted of a competency validation and post- test. Also, a training video was viewed along with the above competency located on the Beverly Information Link (BIL). Presently 70% completed by nursing in the following areas: Critical Care, Acute Care Service and Emergency Care Center (ECC). To be included in future staff meetings, nursing staff will be reminded to clarify any conflicting orders received from a physician or two (2) different physicians. Monitoring Process: Critical care, Medical/Surgical Services and ECC will provide an update report showing the percentage of licensed staff with completed swallow screening Competency Validation and Post swallow screening test to Quality Council for six (6) consecutive months (2 Qs).	04/2014 on-going 01/2015

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	distribution to the nasal wall and septum). The artery was cauterized (a procedure to stop persistent bleeding from a vein or artery) at the area where it was bleeding using the suction cautery (electrosurgical device). The patient was transferred to the intensive care unit after the procedure. The Inpatient Nursing Note dated [redacted] 2012, at 7:52 p.m., disclosed at 6:15 p.m., Employee 1 (registered nurse) "attempted 5 times to insert NG tube as ordered however, unsuccessful. Employee 2 (registered nurse) "attempted once to insert NG tube as ordered however, unsuccessful. Will endorse to night shift registered nurse to retry and family would like another nurse to try." Employee 1 and 2 were unavailable to be interviewed. The Inpatient Nursing Notes dated [redacted] 2012, at 1:50 p.m., disclosed Employee 2 (registered nurse) was successful in inserting the NGT and connected the tube to continuous suction to prevent aspiration. The Inpatient Nursing Notes dated [redacted] 2012, at 6:53 p.m., by Employee 3 (registered nurse) disclosed Patient 1 was transferred to SCU (surgical care unit) 7 due to epistaxis (bleeding from the nose) and coughing up blood since 1:50 p.m. per report. According to the Nursing Notes the "Patient was still without control of nose bleeding and coughing up blood."		Responsible Persons: Nursing Directors of Critical Care, Medical / Surgical, Emergency Care Center and Education Manager Through staff meetings, huddles, saturation meetings, nursing staff will be reminded when inserting a NGT after two (2) attempts, they will call for assistance (e.g., charge nurse).	12/2014

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	A review of a Consultation Report dated [redacted] 2012, by Physician 1, disclosed the reason for consultation was hemoptysis (the coughing up of blood or bloody sputum from the lungs or airway. It may be either self-limiting or recurrent). Patient 1 was hypotensive (low blood pressure) and was having blood suctioned from his airway. The physician's assessment included acute or chronic respiratory failure, hemoptysis may be in part due to the Lovenox medication. The plan was to hold Lovenox medication. The Consultation Report dated [redacted] 2012, by Physician 2, disclosed reason for consultation was nose bleed. The patient was hypotensive and had blood suctioned out from the airway. Patient 1 was intubated and a naso-gastric tube was placed. "However, since the placement of the NGT, there had been intermittent bleeding from the nose. This morning the bleeding was significant and a lot of clots came out from the mouth in addition to the nose." Further review of the consulting physician notes disclosed "nose bleed most likely secondary to naso- gastric tube intubation trauma." The Operative Report dated [redacted] 2012 disclosed preoperative diagnosis of right nasal bleeding and the procedure performed was endoscopic control of nasal bleeding under general anesthesia. On May 8, 2013, at 11:45 a.m., during an interview, Employee 4 (Director of Critical Care Unit) was			

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	asked how many attempts are made under the standard of care for insertion of a NG tube. Employee 4 stated after 2- 3 unsuccessful attempts the licensed nurse should have informed the charge nurse and notify the physician. Employee 4 reviewed the clinical record and stated she was unable to find documentation that the physician was notified of the unsuccessful attempts to insert the NG tube and there was no documentation by the registered nurse on why the NGT was inserted. On January 3, 2014, at 8:45 a.m., a review of Employee 1's Orientation Competency Assessment- and Registered Nurse-Telemetry for the period June 18, 2012 through September 18, 2012 was conducted with Employee 4 (director of critical care). According to the Orientation Competency Assessment of Employee 1, the competency validation was conducted by Employee 5 (registered nurse/preceptor) on August 30, 2012. The Orientation Competency Assessment of Employee 1 was also signed by Employee 4. Employee 1 assessed her level of competency for insertion of NG tube a "1" which was defined as "minimal experience, need review and supervision" and Employee 5's validation of level of competency of Employee 1 was also "1." The comments section was left blank. Employee 4 was asked how many times was the standard of practice for insertion of a NG tube. Employee 4 stated that from her experience a NG tube insertion should be attempted two (2) times and if unsuccessful then an experience person should attempt to insert the NG tube to prevent harm to		A process review/competency assessment is being conducted with the objective of updating the current nursing competency. The present competency topics are being assessed/revised to ensure that skills listed include: high risk, low volume, and problem prone; thereby simplifying the remediation process. The Education Department will work with nursing to assist with competency verification by reviewing requirements for their specialty area. Also review critical elements, with the purpose of developing in conjunction with the above measurable performance criteria. The Orientation Competency Assessment is being revised to include a remediation plan to address an individual's assessment/skill need when competency assessment is below facility expectations.	02/2014

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	the patient. On January 3, 2014, at 8:45 a.m., Employee 5 reviewed of Employee 2's (registered nurse) personnel files and stated Orientation Competency Assessment was conducted on November 21, 2011. Employee 5 further stated Employee 2 received a score "3"- Performs well and can act as a resource person. A review of a facility's Position Description for Registered Nurse Telemetry dated April 21, 2004, disclosed to provide nursing skills to patients who require monitoring and observation post critical care. The Competencies (Skills): c. disclosed documents and reports of pertinent patient observations. The knowledge A. included two years of acute care nursing was preferred. A review of the Employee 1's file indicated Employee 1's date of hire was [redacted] 2012. Prior to [redacted] 2012, Employee 1's job application indicated her work experience included working as a hemodialysis nurse in a dialysis center and performing dialysis treatment. According to a facility's policy and procedure titled, Competency Validation in Telemetry reviewed on October 2012 and November 2013, stipulated the purpose of nursing staff working in Telemetry would accept patient care assignments based on completed competencies. The Procedure included a completion of an orientation period and a determination would be made on the release of "Orientee" to patient care in the unit. If "Orientee" does not "successfully pass competencies, then a		A process review/competency assessment is being conducted with the objective of updating the current nursing competency. The present competency topics are being assessed/ revised to ensure that skills listed include: high risk, low volume, and problem prone; thereby simplifying the remediation process. The Education Department will work with nursing directors to assist with competency verification by reviewing requirements for their specialty area. Also review critical elements, with the purpose of developing in conjunction with the above measurable performance criteria. The Orientation Competency Assessment is being revised to include a remediation plan to address an individual's assessment/skill need when competency assessment is below facility expectations.	02/2014 02/2014

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	Remediation Plan will be initiated." On January 10, 2014, at 11:32 a.m., during a telephone interview, Employee 4 was asked if there was a Remediation Plan for Employee 1. Employee 4 stated there was no Remediation Plan for Employee 1 that she recalled. She further stated Employee 1 was to seek out an experienced nurse when needing assistance or supervision regarding inserting an NG tube in a patient. A review of Employee 1's Annual Competency Assessment for the time period June 18, 2012 through June 18, 2013, disclosed there was no competency validation for insertion of a NG tube procedure. When asked on January 3, 2014 at 8:45 a.m., if the insertion of the NG tube was done during the annual skills, Employee 4 stated the registered nurses come with the NG tube insertion skill from the nursing school. When asked how do you follow-up with an employee to make sure they can perform a NG tube insertion procedure without supervision as indicated in the facility Orientation Competency Assessment, Employee 4 responded that it was up to the registered nurse to ask for assistance. Employee 4 was asked if the facility had a policy and procedure on inserting a naso-gastric tube and she stated the facility used the standard of nursing practice for inserting a Nasal gastric tube. A review of the policy and procedure titled Patient Care dated as reviewed on 11/2005, stipulated the following texts will provide direction and information for performance of procedures that relate to basic		Will continue to develop competencies that will address high risk, low volume, and problem prone; thereby simplifying the remediation process. The Education Department will work with nursing directors to assist with competency verification by reviewing requirements for their specialty area. Also review critical elements, with the purpose of developing in conjunction with the above measurable performance criteria.	04/2014

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	nursing care. According to the "Lippincott Manual" procedure guideline, Chapter 18, "If obstruction appears to prevent the tube from passing, do not use force. Rotating gently may help. if unsuccessful, remove tube and try another nostril. The facility's failure to ensure its policy and procedure on competency assessment for staff performance for naso-gastric (NG) insertion was implemented to ensure Employee 1 was competent and could performed the procedure for inserting an NG tube on the patient with no incidents of nose bleeding, is a deficiency that has cause, or is likely to cause serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of the Health and Safety Code Section, 1280.1. This facility failed to prevent the deficiency(ies) as described above that caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1(c).		At this time, we are continuing to review and revise orientation evaluations/annual competencies. Nursing staff will also be reminded to utilize the "Lippincott Manual" procedure guidelines with emphasis on Chapter 18 - available on our Beverly Intranet (BIL).	12/2014