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
	052052	A. BUILDING _____ B. WING _____	02/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kindred Hospital Riverside	2224 Medical Center Dr, Perris, CA 92571-2638 RIVERSIDE COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00514989 - Substantiated Representing the Department of Public Health: Surveyor ID # 1899, 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 1280.3(g): 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. Health and Safety Code section 1280. (3) (a) Commencing on the effective date of the regulations adopted pursuant to this section, the director may assess an administrative penalty against a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 for a deficiency constituting an immediate jeopardy violation as determined by the department up to a maximum of seventy-five thousand dollars ($75,000) for the first administrative penalty, up to one hundred thousand dollars ($100,000) for the second subsequent administrative penalty, and up to one hundred twenty-five thousand dollars ($125,000) for the third and every subsequent violation. An administrative penalty issued after three years from the date of the last issued immediate jeopardy			

Event ID:EMIL11 3/1/2018 4:31:50PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

CEO 3/14/18

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 7

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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	violation shall be considered a first administrative penalty so long as the facility has not received additional immediate jeopardy violations and is found by the department to be in substantial compliance with all state and federal licensing laws and regulations. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section. Planning and Implementing Patient Care, Title 22, Division 5, Chapter 1, Article 3, Section 70215 (a) Registered nurse shall directly provide: (1) Ongoing patient assessments as defined in the Business and Professions Code, section 2725 (b) (4). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area. (b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission. (c) The nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, the patient's family, or other representatives, when appropriate and staff of other disciplines involved in the care of the patient. Nursing Service Policies and Procedures, Title 22, Division 5, Chapter 1, Article 3, Section 70213		Corrective Action Plan: A. How the plan of correction will be accomplished both temporarily and permenant for clients of the facility that have been found to be affected by the deficient practice(s): * The manager of radiology and/or the DQM will monitor compliance of the nursing departments documentation of assessments, care plans and communication with patients, family or responsible party and that all concerns are addressed and that documentation is being done and fully completed in a timely manner and that everyone is in agreement with plan of care, this began immediately.	9/14/2016

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	(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. Based on interview and record review, the facility failed to develop a plan of care to ensure interventions were in place to prevent Patient A from removing her tracheal tube (TT- a tube surgically inserted into the neck to support breathing). The transferring facility, the patient's family, and Respiratory Therapist (RT) 1 informed the facility of attempts by the patient to remove her endotracheal tube. This failure may have or had the potential to contribute to Patient A's death. Findings: A review of Patient A's clinical record indicated Patient A was admitted to the facility on August 2, 2016, at 9 p.m. with diagnoses to include acute respiratory failure, a history of falls, acute kidney failure, and left ankle fractures. The record indicated Patient A required mechanical ventilation (machine assisted breathing) through her TT. Progress Notes from the referring facility dated August 2, 2016, at 12 p.m., indicated Patient A moves her right arm, "Which she tries to pull on trachea tubing." The notes further indicated Patient A was transferred to the facility for further long term care on August 2, 2016.		B. How the facility will identify other clients who have the potential to be affected by the same deficient practice(s) and how the facility will act to protect clients in similiar situations: * All of the clients in our facility have an admission assessment done that includes the need for restraints and care plan created that is specific to their needs.This will be verified by the charge nurse and audited by the manager of radiology and/or DQM to ensure compliance. C. What mesures will be put into place or systemic changes made to ensure that deficient practice(s) do not recur: * LTACH plan of care creation or adding training was done with all RN's to ensure competency and the restraint freedom program, Verification of compliance by the charge nurse with each admission and auditing by manager of radiology and/or DQM.	9/14/2016 9/14/2016

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	Respiratory Therapist, (RT) 1's assessment notes dated August 2, 2016, at 11:26 p.m. indicated, "Decannulation (pulling out the TT) risk factors: (patient) disoriented, pulling at lines." The "Nursing Admission" notes dated August 3, 2016, at 1: 51 a.m., indicated Patient A arrived at the facility by ambulance at 9 p.m. The notes further indicated the following: "Behavior: Alert, anxious Mental Status: Confusion/disorientation/sedation Affect/mood: anxious." There was no documentation that indicated Patient A's TT was assessed by nursing. Nurse's notes dated August 3, 2016, at 6 a.m., indicated safety interventions in place were "Side rails up x 2, Bed in low position, Call light within reach, Personal items within reach, Assistive devices in reach, ID band." There was no documentation to indicate interventions to prevent the patient from removing her TT were in place. The document titled "Rapid Response Team and Code H Record" dated August 3, 2016, at 11:15 a.m., indicated "Pt. is decannulated. Found by... (names of two nurses)...Pt. seen. Vent (ventilator-breathing machine) alarm going off. Went to see Pt. and found trach (TT) almost out...Attempted (respiratory staff) to place back tracheostomy tube but unsuccessful..."		D. How will the facility monitor it's corrective action/performance to ensure that the deficient practice is/are being corrected and will not recur: * The manager of radiology and/or the DQM will conduct audits of 10% or 4 electronic records per month for care plan completion specific to patients needs including the need for restraints, admission assessments and discussion with patient, family or responsible party on plan of care to ensure compliance E. When corrective action(s) must be accomplished: The corrective actions were ongoing for 2 months or until a threshold of 100% compliance was met, audits will continue to be randomly done for continued compliance, the CCO will monitor. This will be taken to Quality Council and Governing Board for approval.	9/14/2016 10/3/2016

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	A review of a change of condition note documented by RN B, on August 3, 2016, at 5:08 p.m., was conducted. The record indicated, "Rapid response called to my Pt. (patient), saw the patient awake, restless and tracheostomy tube decannulated (pulled out)...code Blue called (cardiac arrest)...Pt expired at 11:48 a.m., (on August 3, 2016)." An interview was conducted with Patient A's family member (FM) on December 20, 2016, at 5:45 p.m. The FM stated she was at the facility with Patient A from 9 p.m., August 2, 2016, until 5:45 a.m., on August 3, 2016. The FM stated she told RN A that at the previous facility, they placed mittens on Patient A's hands to prevent her from pulling out her "tubes," (TT). The FM stated she called the facility on August 3, 2016, at 9:30 a.m., and told them Patient A will pull out her "tubes", and that she needed mittens placed. An interview was conducted with RT 1 on December 21, 2016, at 3 p.m. RT 1 stated when he did an assessment of Patient A on August 2, 2016, at 11:26 p.m., he notified the Registered Nurse, (RN) A that Patient A was moving her arms. He stated he told RN A the patient needed mittens (to prevent her from removing her TT). RT 1 further stated Patient A's family came to visit the patient 45 minutes after his assessment. He stated the family was trying to keep the patient calm because the patient was trying to pull the TT. RT 1 stated Patient A did not have restraints (mittens) placed during his entire shift which ended at 6 a.m.			

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	An interview and record review was conducted with the Director of Quality Management (DQM) on December 20, 2016, at 4:30 p.m. The DQM stated "Occasionally we use mittens/restraints if (the patient) is pulling at lines, we need a physician's order. The nurse makes the decision." The DQM stated the record failed to show a plan of care was developed that addressed the patient's attempts to remove the TT. The DQM further stated Patient A was not assessed for the use of restraints or less restrictive measures (mittens) in order to prevent Patient A from removing her TT. A review of the facility policy, "Physical Restraints (Violent and Non-Violent Behavior) and Seclusion" (Release Date: 6/2016) indicated that the facility utilizes "the Restraint Freedom Program to reinforce a culture that assesses patients at risk for restraint use.... Upon or prior to admission, licensed staff will review the PACE form (pre-Admission Clinical Evaluation), patient/family interview, review of discharge summary or other records/communication provided by the referring facility for prior restraint use risk factors for potential restraint use and communicate findings to the RN responsible for care of the patient... Clinical justification for the restraint use, describing the unsafe situation and how it impacts the patient's safety including: * What less restrictive measures have been considered or attempted... * A determination that the risks associated with			

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	restraint use are outweighed by the risk of not using them (or using a less restrictive alternative)." The facility failed to develop and implement a plan of care to ensure interventions were in place to prevent Patient A from removing her TT. In doing so the facility also failed to implement their established patient care policy and procedure pertaining to physical restraints and seclusion. These failures are deficiencies that have caused, or are likely to cause serious injury and/or death to the patient, and therefore constitute an immediate jeopardy within the meaning of Health and Safety Code, Section 1280.3. 2 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 1280.3(g).			