

*P.O.C. accredited
sc 10/2/09*

California Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA930000044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/14/2009
NAME OF PROVIDER OR SUPPLIER MARINA DEL REY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 4650 LINCOLN BLVD, MARINA DEL REY, CA 90291	
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E000	<p>Initial Comments:</p> <p>The following reflects the findings of the Department of Health Services during a Complaint visit:</p> <p>Complaint Intake Number: CA00136742</p> <p>The inspection was limited to the specific complaints investigated and does not represent the findings of a full investigation of the facility.</p> <p>Representing the Department of Public Health: [REDACTED] RN, HFEN</p> <p>1280.1(c) Health & Safety Code Section 1280</p> <p>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 likely to cause, serious injury or death to the patient</p>	E000	<p>Plan of Correction submitted in response to CMS 2567 received by Hospital on 09/18/09.</p>	
E291	<p>T22 DIV5 CHI ART3-70215(a)(1) Planning and Implementing Patient Care</p> <p>(a) A registered nurse shall directly provide:</p> <p>(1) Ongoing patient assessments as defined in the Business and Professions Code, Section 2725(d). 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.</p> <p>This RULE: is not met as evidenced by:</p> <p>Based on staff interview and record review, the facility failed to ensure a registered nurse directly provided an ongoing assessment for Patient A's respiratory status by failing to continuously assess the patient oxygenation status when the strip (cardiac rhythm) report of the patient was showing decreased oxygen saturation over a 24 minute time interval. This failure resulted in a decrease in oxygen saturation for the patient, a "Code Blue" being called, and the patient being intubated and connected to a ventilator.</p>	E291	<p>Plan of Correction:</p> <ol style="list-style-type: none"> The ICU Nursing Director conducted in-services with all ICU nursing staff regarding the following: <ol style="list-style-type: none"> Standards related to the assessment of critically ill patients; planning, implementation and evaluation of nursing care in the Intensive Care Unit. Standards for documentation of patient assessments on the "24 Hour Critical Care Flowsheet" in the ICU; routine monitoring as well as changes in condition. Procedure for administering oxygen therapy; nursing assessment, interventions and monitoring. Procedure for oxygen saturation monitoring by pulse oximetry; nursing assessment, interventions and monitoring. 	10/5/09

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

TITLE

(X6) DATE

Matthew Jensen Risk Mgr

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	<p>(continued from Page 1)</p> <p>Findings:</p> <p>A review of Patient A's clinical record on August 29, 2008, disclosed the patient was admitted to the facility on March 16, 2007 with diagnosis of left-sided pneumothorax, history of congestive heart failure and emphysema. On March 19, 2007 the patient was transferred to the Intensive Care Unit (ICU) for "continued observation."</p> <p>A review of the Thoracic Surgical Consultation Report dated March 17, 2007 disclosed Patient A's oxygen saturation reading on a non-rebreathing mask was 90 percent. Patient A's oxygen saturation reading dropped to the "mid 70s" when the patient removed the non-rebreathing mask. According to the AACN (American Association of Critical Care Nurses) Procedure Manual for Critical Care (5th Edition), which is referred to in the facility's ICU policies/procedures, "oxygen saturation is an indicator of the percentage of hemoglobin saturated with oxygen at the time of the measurement. Oxygen saturation values obtained from pulse oximetry (SpO2) represents one part of a complete assessment of a patient's oxygenation status. Normal oxygenation saturation values are 97% to 99% in a healthy individual breathing room air. The non-rebreathing mask can deliver nearly 100% oxygen to the patient."</p> <p>A review of the cardiac rhythm strip report, dated March 29, 2007 disclosed Patient A had a decrease in her oxygen saturation rate over a 24 minute period with the SpO2 (pulse oximetry) ranging from 22 down to 6 percent. It was noted on the Strip Report that at 3:23 a.m. the SpO2 rate had dropped to 22 percent with a heart rate of 109, and at 3:47 a.m., the SpO2 dropped to 6 percent with a heart rate of 53.</p> <p>A review of the 24 hour critical care flowsheet, dated March 29, 2007 at 3:48 a.m., documented the patient had removed her non-rebreather mask and her oxygen saturation reading had dropped to 59 percent with a heart rate of 44. According to the flowsheet, at 3:48 a.m., the patient was non-responsive, the nurse began manually bagging the patient and called a Code Blue.</p>		<p>2. Annual Competency Assessments (core nursing and ICU-specific) are being completed with all ICU nursing staff as part of the annual evaluation requirement (see attached Annual Evaluation Checklist and Competency Assessment). Competency Assessments have been revised to include:</p> <ul style="list-style-type: none"> • Documentation of nursing assessments and interventions using the 24 Hour Critical Care Flowsheet • Nursing considerations for oxygen therapy and use of the pulse oximeter. <p>3. Competency Assessments are completed during the orientation period for new hires and are updated annually as part of the annual evaluation process.</p> <p>Responsible: Chief Nursing Officer and ICU Nursing Director</p> <p>Plan for monitoring compliance:</p> <p>1. For the next 90 days, all ICU patient records (100%) will be audited daily for compliance with the following:</p> <ul style="list-style-type: none"> a. Compliance with documentation of patient assessments, monitoring, and nursing interventions on the "24 Hour Critical Care Flowsheet according to unit protocol. b. For patients with pulse oximetry monitoring, any noted fluctuations in oxygen saturation are documented in the record along with nursing care measures implemented, and patient's response. c. Any significant changes in patient condition are documented in the record along with nursing care 	<p>10/5/09</p> <p>Ongoing monitor for 90 days to be completed Jan 01, 2010</p>
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	<p>(continued from Page 2)</p> <p>There was no documented evidence on the 24 hour critical care flowsheet that a registered nurse provided an ongoing assessment of Patient A's condition when the patient's oxygen level, based on the cardiac rhythm strip report, was desaturating. There was no documented evidence that Patient A's oxygen desaturation level was being acted upon, or interventions performed, by the facility's nursing staff on March 29, 2007, during the 24 minute time interval from 3:23 a.m. to 3:47 a.m.</p> <p>A review of Patient A's Code Blue record, dated March 29, 2007, disclosed that at 3:48 a.m., the patient had a cardiopulmonary arrest and CPR (cardiopulmonary resuscitation) was initiated. The 24 hour critical care flowsheet, dated March 29, 2007 at 4:05 a.m., revealed the patient was intubated and was connected to a ventilator. A review of the Cardiology follow-up progress notes, dated March 30, 2007 at 5:40 p.m., revealed the patient had a witnessed cardiac arrest secondary to hypoxia (a pathological condition in which the body as a whole or a region of the body is deprived of adequate oxygen supply).</p> <p>During a telephone interview with Employee 6 on September 9, 2008 at 8:40 am, she stated the patient was not wearing the non-breathing mask when she entered the patient's room on March 29, 2007, when Patient A's oxygen saturation level suddenly dropped.</p> <p>During a telephone interview with Employee 7 on September 9, 2008 at 8:50 am, she stated she had alerted Employee 4 to assess the patient if she was wearing the non-rebreathing mask because the patient was having abnormal oxygen saturation readings. Employee 7 also stated that Employee 4 was a registry nurse and could not be interviewed at the time of the investigation.</p> <p>The facility failed to ensure that a registered nurse directly provided an ongoing assessment of Patient A's respiratory status by failing to continuously assess the patient's oxygenation status when the strip report of the patient was showing decreased oxygen saturation over 24 minutes. This failure resulted in decreased oxygen</p>		<p>measures implemented, and patient's response.</p> <ol style="list-style-type: none"> ICU documentation audits will be reviewed weekly by the ICU Nursing Director and forwarded to the Chief Nursing Officer (CNO). Summary reports will be submitted to the hospital Quality Council monthly to include measure of compliance and a description of corrective actions taken for any evidence of non-compliance. If overall compliance is above 96% for 90 days, audits will continue weekly with monthly reporting to the CNO and Quality Council. Nursing staff who fail to perform to nursing care standards of documentation are subject to disciplinary action according to HR policies and procedures. <p>Responsible: Chief Nursing Officer and ICU Nursing Director</p>	<p>Ongoing</p>
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	(continued from Page 3) saturation, a Code Blue being called, and the patient being intubated and connected to a ventilator. The facility's failure to ensure a registered nurse directly provided an ongoing assessment for Patient A's respiratory status and continuously assess the patient's oxygenation status, when the cardiac monitor strip report documented decreased oxygen saturation levels, is a deficiency that has caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health & Safety Code Section 1280.1.				

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Matthew Thurston

Robt Myers

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