PRINTED: 01/13/2017
FORM APPROVED

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA070001957	A. BUILDING: CALIFORNIA DEPARTMENT OF PUBLIC HEALTH B. WING	C 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANFORD HEALTH CARE	300 PASTEUR DRIVE STANFORD, CA 94305

FEB - 3 2017
L & C DIVISION
SAN JOSE

(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
E 000	Initial Comments The following reflects the findings of the California Department of Public Health during a complaint investigation conducted on 8/8/16 through 8/10/16, 8/15/16, 8/17/16, 8/18/16 and 8/19/16. For Complaint CA00478561 regarding Quality of Care/Treatment, a state deficiency was identified (see California Code of Regulations, Title 22, Section 70213(a)). The Department has determined this noncompliance has caused, or was likely to cause, serious injury or death to the patient, and therefore constitutes a state "Immediate Jeopardy" within the meaning of the Health and Safety Code, Section 1280.3(g). Inspection was limited to the complaint investigated and does not represent the findings of a full inspection of the hospital. Representing the California Department of Public Health was 25721, Health Facilities Evaluator Nurse.	E 000	**Tag E000 Initial Comments** Preparation and submission of this Plan of Correction does not constitute an admission or agreement by Stanford Hospital (the "Hospital") of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Hospital is submitting this Plan of Correction as required by state and/or federal regulations. This Plan of Correction documents the actions by the Hospital to address the alleged deficiencies. This Plan of Correction constitutes credible evidence of compliance with the cited regulations.	
E 264	T22 DIV5 CH1 ART3-70213(a) Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. This Statute is not met as evidenced by: Based on interview, and record review, the hospital failed to implement their enteral nutrition (tube feeding) policy and procedure for Patient 1 when a gastrostomy tube (GT, a flexible feeding	E 264	**Tag T22 DIV5 CH1 ART3-70213(a) Nursing Service Policies and Procedures** **Immediate and Permanent Corrective Action:** The Gastrostomy Site Care policy was updated to reflect current Evidence-Based Practice related to placement and securement of G-tubes which now includes: • Measurement and documentation of tube length in Electronic Health Record • Notify MD for X-ray for verification of placement if length of tubing has changed • If at any time, RN suspects tube dislodgment or malposition, notify MD for X-ray • Secure tube to abdomen with Stat-Lock	

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Preet Saini
TITLE: Quality Consultant, RN, BSN
(X6) DATE: 2/3/17

2/3/17
POC accepted
N.E.

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E 264	Continued From page 1 tube placed through the abdominal wall and into the stomach) was secured with a safety pin instead of a Stat-lock or tape secured to the abdomen. This failure resulted in dislodgement of the tube. Findings: The hospital's policy and procedure titled "Enteral Nutrition" dated 1/2014 was reviewed on 3/9/16. The policy and procedure indicated to "secure the gastrostomy tube to abdomen with paper tape. This prevents excess movement of tube and subsequent tract erosion. Use Stat-lock or tape to secure tube helps prevent tube dislodgement." Patient 1's record was reviewed on 3/8/16. Patient 1 was admitted to the hospital on 1/11/16 for a scheduled mitral valve surgery with diagnoses including mitral valve prolapse and high blood pressure. During an interview on 3/15/16 at 7:50 a.m., registered nurse A (RN A) stated she was Patient 1's primary nurse on 2/21/16 for the 7 p.m. to 7 a.m. shift. RN A stated Patient 1 was stable at the start of the shift with no unusual problems and was on continuous tube feeding through the GT. RN A stated she checked the GT residual (amount and type of fluid in the stomach) using a syringe to aspirate the stomach contents near the beginning of the shift. She stated there was a small amount of tube feeding in the aspirate, which was normal. During an interview on 3/15/16 at 8:10 a.m. registered nurse B (RN B) stated she took care of Patient 1 on 2/22/16 at 12:30 a.m. while RN A was on lunch break. RN B stated around 12:30 a.m., she went into Patient 1's room and found	E 264	Cont. Huddle sheets were created and circulated to all staff on D3 unit on 2/22/2016 and to all advanced practice providers (nurse practitioners, physician assistants, and clinical nurse specialists) on 4/4/2016 to reinforce proper securement of G-Tubes. On 3/28/2016, A "Knowledge, Skills, and Assessment" check off tool was created and used to reinforce hospital policy with all staff on D3. On 3/18/2016, A G-Tube education flyer was created and circulated to all staff via the weekly nursing newsletter by the Chief Nursing Officer. On 4/20/2016 and 5/4/2016, an in-service for inpatient and outpatient advanced practice providers (nurse practitioners, physician assistants, and clinical nurse specialists) was conducted with the help of a huddle sheet titled, "4 Things Providers Should Know About PEG and G-Tubes" **Monitoring Process:** As of March 18, 2016, all G-Tubes have been monitored daily for proper securement and documentation of standard nursing care until a compliance rate of 100% was received for 3 consecutive months. **Responsible Party:** Director of Nursing Quality	02/02/2017

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E 264	Continued From page 2 him in bed with his gown pulled up to his chest area. RN B stated the GT was pinned to Patient 1's gown via a safety pin, and the GT was pulled out about 2 centimeters (about an inch) from where it should normally be. RN B stated she stopped the tube feeding. RN B stated she called physician's assistant A (PA A) to check the GT. RN B stated PA A examined Patient 1 and manipulated the PEG tube. RN B stated PA A told her it was "OK" to resume the tube feeding. RN B stated she resumed the 50 cubic centimeters (cc)/hour tube feeding. RN B stated she did not check the GT residual. Review of Patient 1's cardiac surgery progress addendum note dated 2/22/16 documented by PA A indicated the following: The patient pulled his hospital gown up towards his head. His GT was pinned to his gown and moved out approximately 3 centimeters (cm). PA A went to see the patient at 2 a.m. and the patient was complaining of abdominal pain. The abdominal exam otherwise was benign. The patient was treated with intravenous toradol (a pain medication). At 3:30 a.m., PA A was called again to see the patient. The patient's blood pressure was 50. He was started on medications to raise his blood pressure without improvement. The patient was in respiratory distress, and was prepared for transport to the intensive care unit (ICU). Prior to transport the patient had 500 cubic centimeters (cc) of frank bloody emesis. During an interview on 3/17/16 at 8 a.m., PA A stated based on her initial examination and vital signs at 2 a.m. on 2/22/16 she did not believe Patient 1's GT was dislodged. PA A stated she did not check GT residual, and she did not order an X-ray to check the GT placement as she did not believe it was dislodged.	E 264	This page was intentionally left blank	

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E 264	Continued From page 3 During an interview on 3/8/16 at 1:35 p.m., the patient care coordinator nurse (PCCN) stated pinning a GT to a patient gown was not a standard practice at the hospital. The PCCN stated when GT placement was in doubt, tube feedings should be stopped and a residual check should be performed. The PCCN stated the medical team should be notified and placement of the GT should be confirmed by X-ray before use. During an interview on 3/8/16 at 2:10 p.m., the physician assistant supervisor (PAS) stated an X-ray should be obtained to check placement of a GT if the position of the tube has moved. Review of Patient 1's enteral feeding flow sheet on 2/21/16 indicated Patient 1 received Jevity 1.5 (a liquid nutrition formula) via the GT at 50 cc per hour continuously. The flow sheet indicated gastric residual was checked at approximately 8 p.m. and the result was documented as "0." The enteral feeding flow sheet on 2/22/16 indicated Patient 1 received approximately 100cc of formula and 60cc of water via the GT in the interval from 12 a.m. to 2 a.m. Review of Patient 1's operation report dated 2/22/16 documented a preoperative diagnoses of "acute GI bleed secondary to G-tube dislodgement; postoperative diagnoses: same." The report further indicated "the patient is a 72 male who is approximately 2 months out from mitral valve repair. His postoperative course has been complicated and he is currently in the CVICU s/p/ tracheostomy and PEG placement on 2/4/16. Overnight, he went into hemorrhagic shock with DIC. There was a concern that his gastrostomy tube has been dislodged given	E 264	This page was intentionally left blank	

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E 264	Continued From page 4 hematemesis and hemorrhage via the GT site associated with an abdominal wall hematoma. The GI team scoped him and found significant blood clots but no visible areas of active bleeding in the stomach or duodenum. The gastrostomy tube was not found within the stomach during the EGD" (esophagogastroduodenoscopy). During an interview on 3/18/16 at 2:35 p.m. with Patient 1's primary physician, he stated the dislodged GT, subsequent bleeding, and low blood pressure led to sepsis and was a contributing cause of Patient 1's death. Review of Patient 1's death summary dated 3/4/16 indicated the principle diagnosis at the time of death was septic shock, gastrointestinal bleeding, PEG tube malfunction and acute blood loss anemia. Review of Patient 1's death certificate indicated Patient 1's immediate cause of death was respiratory failure with bowel perforation non-traumatic, complication of mitral valve repair and mitral valve regurgitation. Other significant conditions contributory to death was altered mental status metabolic encephalopathy.	E 264	This page was intentionally left blank	