POC – acceptable
1/3/17 bm

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
	05-2050	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kindred Hospital South Bay	1246 W 155th St, Gardena, CA 90247-4011 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: CA00433321 - Substantiated Representing the Department of Public Health: Surveyor ID # 17030, 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. Title 22 DIV 5 ART 3 70215(a)(2) and (b) Planning and Implementing Patient Care. (a) A registered nurse shall directly provide: (2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation. (b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning,		**Title 22 DIV 5 ART 3 70215(a)(2) and (b) Planning and Implementing Patient Care** **Title 22 DIV 6 ART 6 70617(c)(d) Respiratory Care Service General Requirements** **Title 22 DIV 5 ART 3 70263(g)(2) and (b) Pharmaceutical Services General Req** **Immediate Actions:** Upon notification of the event Director of Quality Management initiated an investigation and Root Cause Analysis. To ensure ongoing patient safety and completion of investigation staff members involved with event were suspended, this included a RT, RN and house supervisor. Following completion of investigation House Supervisor was terminated and other staff received written counseling which included failure to follow physician orders and escalation of events. Education was provided to all RNs, LVN's, House Supervisors and RT's on the following topics: • Process for escalation of events • Necessity for physician orders for all medications or treatment changes • Necessity for physician notification when unable to perform ordered medications/treatments • Notification process for when a patient has a change of condition • Safe decision making and critical thinking	6/30/2015

Event ID:YIF31 Maane Chacra 12/7/2016 10:27:05AM CEO 1-3-17

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

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 11

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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	Intervention, evaluation and, as circumstanses require, patient advocacy, and shall be initiated by a registered nurse at the time of admission. Title 22 DIV5 ART 6 70817(c)(d) Respiratory Care Service General Requirements. (c) There shall be clear delineation as to who may perform the various procedures, under what circumstances and under whose supervision, with the important undesirable side effects noted if an emergency arises. (d) All services shall be provided on the order of a person lawfully authorized to give such an order and shall specify the type, frequency of treatment, the dose and type of medication, appropriate dilution ratios and which diagnostic procedures are requested. Title 22 DIV 5 ART 3 70263(g)(2) Pharmaceutical Services General Requirements (g) No drugs shall be administered except by licensed personnel authorized to administer drugs and upon the order of a person lawfully authorized to prescribe or furnish. This shall not preclude the administration of aerosol drugs by respiratory therapists. The order shall include the name of the drug, the dosage and the frequency of administration, the route of administration, if other than oral, and the date, time and signature of the prescriber or furnisher. Orders for drugs should be written or transmitted by the prescriber or furnisher. Verbal orders for drugs shall be given only by a		House Supervisor hand off report was updated to include: location and room numbers of all patients on Bipap and ventilators. The report also includes environmental concerns. All patients affected by outage were assessed to determine that no untoward events had occurred. All family members were notified of occurrence. **System Changes:** The process for communication with the house supervisor was changed to include more frequent communication with Administrator On Call (AOC). This communication includes weekend conversations and focuses on patients with change of condition and any environment building related issues. Notification related to change of condition content/education was added to General Hospital Orientation for all staff. **Monitoring:** Auditing appropriateness of documentation related to change of condition, which includes physician notification is conducted monthly on a minimum of 30 change of condition episodes.	

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	person lawfully authorized to prescribe or furnish and shall be recorded promptly in the patient's medical record, noting the name of the person giving the verbal order and the signature of the individual receiving the order. The prescriber or furnisher shall countersign the order within 48 hours. (2) Medications and treatments shall be administered as ordered. T22 DIV5 CH1 ART8-70841(a)(1) Emergency Lighting and Power System (a) Auxiliary lighting and power facilities shall be readily available at all times. (1) The emergency lighting and power system shall be maintained in operating condition to provide automatic restoration of power for emergency circuits within ten seconds after normal power failure. This Statute is not met as evidenced by: Based on record review and staff interviews, the facility staff failed to follow the physician's order to have Patient A on a BIPAP (Bilevel Positive Airway Pressure) at night and supervise the patient's care when the emergency power system failed. On March 1, 2015 at 11:50 a.m., a power outage occurs and, the emergency power system did not provide power due to a burnt out transformer. Subsequently, the patient's BIPAP machine turned off, and a Venturi mask was applied to Patient A. The physician was		**Monitoring (cont):** CEO, CCO, DQM receive and monitor supervisor handoff daily to ensure completeness and that issues are being appropriately escalated. Change of condition to include physician notification was added to annual RT competency. **Responsible Person:** Chief Clinical Officer	

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	not notified of the change of treatment modality from BIPAP machine to a Venturi mask. The patient, who was located on the telemetry unit, was not moved to another room with electrical power. As a result, at 1:10 a.m. on March 2, 2015, one hour and twenty minutes after placing the patient on a Venturi mask, a Code Blue (code used in a hospital for life threatening medical emergency) was called. Patient A was unresponsive, with agonal (labored) breathing and bradycardia (Heart rate under 60 beats per minute in an adult). Patient A expired at 2:10 a.m. A BIPAP machine that required electrical power and delivers pressurized air through a mask to the patient's airways by forcing the air to the patient. AVenturi mask [brand name Ventimask] is a medical device used to deliver a known oxygen concentration to patients on controlled oxygen therapy and no electrical power is needed. Findings: On March 2, 2015, an entity reported incident investigation was conducted in response to a telephone call from the facility to the Department indicating the facility had a power failure that resulted in a patient's breathing machine turning off, the incorrect machine being used, the patient not being transferred to a room with electrical power, ultimately causing the patient ' s death. During an interview with Employee 2 (Chief Engineer) on March 2, 2015, at 11:34 a.m., he stated Employee 3 called him on March 2, 2015 at		T22 DIV 5 CH1 ART 8-70841 (a)(1) Emergency lighting and Power System Immediate Actions: The Chief Engineer was notified by the House Supervisor of a loss of power at Station 1 and was on site to facilitate failure correction within 30 minutes of actual failure. Power cords were established in each room to supply power to bedside equipment. An assessment was completed to determine cause of power failure. The Inspector of Record (IOR) arrived on site March 2nd at 1100 to confirm an emergency repair of the breaker and transformer were needed to restore full power to Station 1 (room numbers 18-29). An electrical engineer arrived on site March 2nd at 1100 to confirm specifications need for replacement of transformer and breaker and to assist with emergency plans and permit submittal. At 0830 on March 2nd a backup generator was ordered and wired into panel L2. It was then tested and full power was restored at 1100. OSHPD, Fire Life Safety Officer and Area Compliance Officer were notified on March 2nd of incident by the IOR.	6/30/2015

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	12:05 a.m. and stated there was no electric power from Room 18 to Room 29, including Patient A's room (Room 27). According to Employee 2, both he and Employee 3 found there was no electric power from emergency outlets because the transformer was "burnt up"(damaged or destroyed by fire, heat, electricity, or a caustic agent). A review of the face sheet indicated Patient A was admitted to the facility on February 20, 2015, with diagnoses of acute and chronic respiratory failure. The patient expired on March 2, 2015. A review of the History and Physical dated 2/21/15 indicated the patient had a history of chronic obstructive pulmonary disease (a type of obstructive lung disease characterized by chronically poor airflow, congestive heart failure, multi-infarct dementia, and end-stage renal disease (a progressive loss in renal function over a period of months or years). A review of the Active Orders dated 3/1/15 at 5:58 p.m. indicated the physician had ordered BIPAP at noc [night]. " Take patient off at 7 a.m. and do an ABG (Arterial Blood Gas, which measures the amount of oxygen and carbon dioxide in the blood to see how well the lungs are working) at 8 a.m. IPAP level 15 EPAP level 5 FIO2 30% without humidification. " (The BiPAP machine has two pressures settings: the prescribed pressure for inhalation (IPAP), and a lower pressure for exhalation (EPAP). FIO2 stands for fraction of inspired oxygen and is a fraction of the amount of oxygen the patient is inhaling produced by an		At 1100 following power restoration, a backup, to the backup generator was ordered to ensure a redundant system of power was maintained. This generator arrived at approximately 1300. Installation began of breaker and transformer on March 3rd and installation was completed by 1330 on March 3rd. Governing board and the Chief of Staff were notified of the event on March 2nd. Plant operations staff remained on site from time of initial failure until transformer and breaker were replaced and full power was restored. **Systom Changes:** A schedule for emergency drills was developed. Disaster supplies and policies were reviewed and updated. All staff was educated on location of disaster equipment and parameters for determining a disaster. RN, RT and House Supervisors involved with event were educated on the use of backup power supply. A temporary containment enclosure was built within 1 week of event to ensure water exposure did not recur.	

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	oxygen device such as mask.) A review of the RT [Respiratory Therapist] Progress Note dated 3/1/15 at 11:50 p.m. (Late entry on 3/2/15 at 3:51 p.m.) indicated RT was called into the patient's room at approximately 11:50 p.m. because the power went out and Patient A was desaturating to the 80's when the BIPAP turned off. The patient was placed on 30% Ventimask and the [oxygen] saturation increased to 97 - 98%. Patient A was monitored for approximately 10 to 15 minutes with RN 1 and RN 2 at bedside. The documentation also indicated that Patient A had no signs and symptoms of respiratory distress at the time but nursing was advised by RT to transfer the patient to a room with working electric outlets and waited for the call back from nursing when patient's room was available or patient's room was fixed. According to the note, before leaving the patient's bedside, patient's oxygen saturation was 97%, heart rate was 101 bpm [beats per minute] RR [respiratory rate] of 24 and RN 1 and RN 2 were notified verbally while at the patient ' s bedside. There was no documentation in the progress note that the patient should be transferred to another room. A review of the RT Progress Note dated 3/2/15, at 15:42 [3:42 p.m.] Late entry, indicated, at approximately 0020 [12:20 a.m.] on 3/2/15, the patient was on a Venturi mask with Peripheral capillary SpO2 (oxygen saturation) 96-97% and was observed without distress. A review of the RT Progress Note dated 3/2/15 at		A new enclosure for the transformer is in process of being built. Initial planning for enclosure was started on March 2nd. Enclosure was approved by OSHPD July 22, 2015 and is expected to be completed by first quarter 2017. **Monitoring:** Enclosure of transformer is assessed daily on daily rounds by plant operations. **Responsible Person:** Chief Executive Officer	

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	2:39 a.m. indicated, at approximately 1:05 a.m., the rapid response team was called to room 27C (Patient A's room) and RT began bagging the patient, as well as transferring the patient to another room that had emergency power to the electrical receptacles. The patient was intubated (a long breathing tube is inserted into the trachea or windpipe through the mouth to permit air to pass freely to and from the lungs to allow air into the lungs). The RT continued bagging and compressing the patient for approximately 40 mins [minutes] until the physician called to stop and pronounced the patient expired. According to the patient's death certificate, the immediate cause of death was cardiorespiratory arrest. A review of the Rapid Response Team and "Code H" Record dated 3/2/15, indicated the Code Blue was called for the patient due to unconsciousness and agonal (labored) breathing. The Code Blue Flowsheet dated 3/21/15 indicated the Code was started from 1:10 a.m. to 1:30 a.m. on 3/2/15. According to the Code Blue Flowsheet, the patient expired at 2:10 a.m. on 3/2/15. During a telephone interview with the monitor technician (MT 1) on March 9, 2015 at 3 p.m., she stated, after 11:55 p.m. on 3/1/15, the heart rhythm for the patient changed from sinus tachycardia (a sinus rhythm that is higher than normal, defined as a rate greater than 100 beats/min (bpm) in an average adult) to sinus brady (Heart rate 40) (a sinus rhythm with a rate that is lower than normal which is generally defined to be a rate of under 60 beats per minute). According to MT 1, she notified			

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	RN 1 immediately. During a telephone interview on March 9, 2015 at 3:05 p.m., Registered Nurse (RN) 1 stated, at 7:03 p.m. on 3/1/15, the patient was on BIPAP with no respiratory distress. At approximately 11:55 p.m. on 3/1/15, RN 1 was told the electric power was off. RN 1 stated RT 1 came by to place the patient on a Venturi mask. According to RN 1, at 00:39 a.m. on 3/2/15, the O2 sats for the patient was 90%. During a telephone interview with RT 1 on March 9, 2015 at 3:23 p.m., he stated, at 11:50 p.m. on 3/1/15, the patient was placed on Venturi mask because the electrical power to the BIPAP airway pressure system was not working due to a power outage. During a telephone interview on March 16, 2016, at 3:15 p.m., RT 1 stated he was not the RT assigned to Patient A. He was in the area (Station 1) and the first one to respond when respiratory was called in the room when the power went out. RT 1 stated the room was dark and the BIPAP was off. RT 1 put a venti mask on the patient. The BIPAP needs to be connected to another electrical outlet to work. RT 1 stated the mask is not the same as the BIPAP. The BIPAP is forcing the air to the patient. RT 1 stated he monitored the patient's oxygen saturation for about 10 minutes. He went out of the room and called the assigned RT. The assigned RT came and checked the patient. RT 1 stated, they both told the nurses the patient needed to be moved. RT 1 stated some rooms had no power, not the whole hospital. When asked if he informed the patient's			

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	physician, RT 1 stated he did not call the doctor. During a telephone interview on March 17, 2016 at 2:15 p.m., RN 1 stated that close to midnight one fourth of the facility had a power outage. RN 1 stated Patient A was on BIPAP, the BIPAP machine had no power and the patient's pulse oximeter (a small device that clips to the finger to monitor oxygen saturation) was indicating the patient's oxygen level dropped. The patient's oxygen saturation was 87-88%. RN 1 stated the charge nurse (RN 2) was with him in the patient's room. They called the RT and the RT placed the patient on a Venturi mask. The patient's oxygen saturation went up to 98-99%. RN 1 stated they made sure the patient was not in respiratory distress, they checked the other patients and then called maintenance because of the power outage. RN 1 stated after thirty (30) minutes, he checked the patient one more time and then took his thirty (30) minute break. RN 1 notified the licensed vocational nurse (LVN) working with him before he went on break to watch all the patients, not just the patient on a Venturi mask. He did not notify the charge nurse or the RT. When asked if he called the physician, RN 1 stated the physician was not called. When asked if he looked for an available bed with power, RN 1 stated they did not look for an available bed. When asked about BIPAP, RN 1 stated, "I don't really know. Not my specialty. Patient was not in respiratory distress." RN 1 stated he did not recall the reason for the BIPAP. RN 1 stated, "I did not see the assigned RT. He might have come. I did not see."			

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	RN 1 further stated the patient was on tele [telemetry] monitor and when he came back from his break, the patient had bradycardia (low heart rate), oxygen saturations 90's [not sure], and short of breath. Rapid response was called. RN 1 stated the charge nurse should be covering for him. She (charge nurse) was doing blood draws for the other RN. When asked if there was communication regarding transferring the patient to another room with power, RN 1 stated the RT did not inform him to transfer the patient to another room and there was no mention of the patient being transferred to another room with power. RN 1 stated, "I believe she was stable. Not short of breath." RN 1 stated there was a meeting after the BIPAP incident and training. During an interview on March 24, 2016 at 3 p.m., RT 2 stated there was much commotion at that time because of the power outage. He was assigned to the patient and was told by a colleague the power went out, the patient was placed on a Venturi mask and nursing was waiting for a room. RT 2 went to see the patient after the Venturi mask was applied. RT 2 stated the nursing (house) supervisor never approached him about finding a room. RT 2 did not inform the physician about applying the venti mask. RT 2 stated it was temporary. When asked if he checked the patient again, RT 2 stated, "I don't remember going back to the room." This facility failed to prevent the deficiency as described above that caused, or likely to cause, serious injury or death to the patient, and therefore			

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	constitute an immediate jeopardy within the meaning of Health and safety Code section 1280.3(g). 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).			