

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050230	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/14/2007
NAME OF PROVIDER OR SUPPLIER GARDEN GROVE HOSPITAL AND MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 12601 GARDEN GROVE BLVD., GARDEN GROVE, CA 92843 ORANGE COUNTY		
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	<p>The following reflects the findings of the Department of Public Health during an investigation of COMPLAINT NO. CA00123170.</p> <p>Representing the Department of Public Health: [REDACTED], HFEN.</p> <p>HSC Section 1280.1(a). If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars (\$25,000) per violation.</p> <p>(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.</p> <p>DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY.</p> <p>T22 DIV5 CH1 ART3-70215(b) Planning and Implementing Patient Care</p> <p>(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.</p>			

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5/12/2008

5:52:12PM

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	<p>Continued From page 1</p> <p>This Regulation was NOT MET as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure that a patient was appropriately assessed and nursing advocacy initiated to ensure clinical interventions were implemented. These failures resulted in delay of treatment for a subdural hematoma and physical decline of the patient. Findings:</p> <p>On 8/15/07 and 8/16/07, the medical record for Patient A was reviewed. The record showed that Patient A was a 74 year old man admitted on 8/3/07 with a diagnosis of chest pain; rule out MI (myocardial infarction) versus chest wall pain. Additional diagnoses for the patient included coronary artery disease, hypertension, and status post coronary artery bypass graft, atrial fibrillation and ESRD (end stage renal disease). The patient was receiving renal dialysis for the ESRD. The patient was initially admitted to the ICU (Intensive Care Unit) and on 8/5/07 was transferred to IOU (Intermediate Observation Unit), a telemetry floor. The MI had been ruled out.</p> <p>While in the IOU the patient was receiving multiple medications including the following:</p> <p>Aspirin 325 mg. tablet daily Plavix 75 mg. tablet daily Lovenox 60 mg. by injection every 12 hours.</p> <p>According to drug information obtained from Rx list (the internet drug index) all three of these drugs increase bleeding times. Lovenox, Plavix, and</p>			
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	<p>Continued From page 2</p> <p>aspirin all impede clot formation in the blood which can lead to hemorrhage, including cerebral hemorrhage. The use of the drugs together increases the possibility of excessive bleeding and/or hemorrhage.</p> <p>On 8/7/07 at 1615 hours, while the patient was in IOU, there was documentation in the nursing outcome notes that the patient fell and sustained an injury to his left forehead. The patient was noted to be alert and oriented after the event, but he was bleeding freely from the forehead laceration. Nursing outcome notes at 1730 hours stated that the patient was going to the bathroom with assistance, with no change in condition, but appeared weaker and tired. Also, the patient refused to eat. Additional notes timed 1930 hours, showed that the patient was alert and oriented times three with bouts of confusion. The nursing flowsheet showed at 2000 hours that the patient was alert and oriented. However, the fall risk screening section of the flowsheet noted several significant changes from the 0800 assessment.</p> <p>The fall risk screening form, divided into several sections, showed the following documentation for 8/7/07 at 0800 hours and 2000 hours:</p> <p>History of falls within the 12 mos. 0800 - No 2000 - No</p> <p>Ambulatory Aid 0800 - No 2000 - No</p>			
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	<p>Continued From page 3</p> <p>IV Access 0800 - Yes 2000 - Yes</p> <p>Gait 0800 - Normal 2000- Weak</p> <p>Mental Status 0800 - Oriented 2000 - Overestimates/forgets limitations</p> <p>The nursing documentation from 1930 hours on 8/7/07 through 0400 hours on 8/8/07 showed that the forehead dressing of Patient A was saturated with blood and was changed or reinforced four times. The 2100 hour dose of Lovenox was held by the nurse but there was no documentation as to why. There was no documentation that the physician was notified of the change in mental status, excessive bleeding from the forehead wound, or that the 2100 hour dose of Lovenox was held.</p> <p>On 8/15/07 at 1100 hours, the P.T (physical therapist) was interviewed. The P.T. stated that on 8/7/07 at approximately 1500 hours she went in to evaluate the patient. The patient was lying in bed with the upper side rails elevated. The P.T. went out to get the patient slippers and when she came back the patient was standing by the bedside and then he fell. The P.T. did not see the patient land because he was behind the bed. When she got to the patient he was sitting up and there was a 1/2 inch laceration on the patient's forehead above the</p>			
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	<p>Continued From page 4</p> <p>left eye. The patient appeared shaken, but what he was saying made sense.</p> <p>On 8/15/07 at 1035 hours during interview, RN #1 the day shift nurse stated that she assisted the patient immediately after the incident. She found the patient sitting on the floor with a 1/2 inch laceration on his forehead above his left eye. The RN stated that the laceration was bleeding a lot. Initially she applied gauze with pressure and ultimately she applied a steristrip. The RN stated that she relayed the incident to the charge nurse but there must have been some miscommunication because she found that the physician had not been called. The RN then called the physician and received a call back with an order to do a CAT scan (computerized axial tomography). The order was read back. The CAT scan was entered into the system by the charge nurse. According to the RN the CAT scan was ordered to be done in the morning because it was not ordered stat.</p> <p>On 8/15/07 at 1330 hours, RN #2 the night shift nurse was interviewed. The RN stated that in shift change report at 0700 hours on 8/7/07, she was told that the patient had fallen and the physician wanted a psychiatric evaluation due to confusion during morning dialysis. At 1930 hours, the RN checked the patient. The patient was oriented with some confusion and had a dressing on his forehead. The dressing was saturated. The RN stated she was not concerned about the confusion because the patient had been confused earlier. The RN stated that the dressing was saturated again at 2030 and was changed. The RN stated that the</p>			
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	<p>Continued From page 5</p> <p>Lovenox 2100 hour dose was held due to excessive bleeding. When asked if the physician had been notified the RN said no. There was a physician's progress note in the chart that showed that one of the patient's consulting physicians had been in after 2030 hours on 8/7/07 to see the patient. When asked if she was aware of the physician's visit, the RN stated she was but she had not seen the physician that evening.</p> <p>According to RN #2, at 0230 hours the patient's forehead dressing was again saturated. She told the charge nurse and was told to notify the physician in the morning. At 0330 the patient told her he wanted to go to breakfast. She reoriented the patient. At 0400 hours the dressing was soaked again and the patient was vomiting. The RN went to get a gown to change the patient and upon return noted that the patient was unresponsive. The physician was called. The physician asked what the results of the CAT scan were. When told it wasn't done the physician ordered it stat. The RN stated that the CAT scan was done and the patient transferred to ICU.</p> <p>Review of the medical record showed a physician's order on 8/7/07 at 1925 hours for a CAT scan without contrast. A physician's progress noted dated 8/7/07 dated but not signed noted that the patient had fallen, vital signs were stable and the patient was alert and oriented. A physician's order was written on 8/8/07 at 0500, for a stat CAT scan of the head without contrast. The CAT scan of the head results showed a large subdural hematoma 3 cm (centimeters) thick with a 2 cm right to left shift.</p>			
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	<p>Continued From page 6</p> <p>The subdural hematoma extends from the frontal to the temporal and occipital lobes of the brain. A large frontal scalp hematoma was noted as well. Upon arrival to the ICU, at 0630 hours on 8/8/07 the patient was assessed as unresponsive with unreactive pupils. At 0930 hours on 8/8/07, the patient had a craniotomy for removal of a large right subdural hematoma. The physician's progress note after the surgery documented that the hematoma was evacuated but the patient probably suffered herniation. The patient was unresponsive after surgery with fixed and non-reactive pupils. The patient's condition never improved and on 8/12/07 the physician's progress notes show that the patient was unresponsive to all stimuli and was pronounced dead at 1230 hours.</p> <p>The nurses caring for the patient in IOU failed to accurately assess the patient, intervene for the patient by notifying the physician of condition changes (including holding a medication), and advocate for the patient by requesting a stat CAT scan order from the physician initially.</p> <p>The violation(s) has caused or is likely to cause, serious injury or death to the patient(s).</p>			
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