POC - acceptable
11/3/09 kn

California Department of Health Services

PRINTED 08/07/2009
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000085	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The following reflects the findings of the Department of Public Health during an Investigation of an entity reported incident. Complaint Intake Numbers: CA00188181 - Substantiated The inspection was limited to the specific complaint/entity reported incident investigated and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: [redacted] RN-Health Facilities Evaluator Nurse 1280.1(c) Health & Safety Code Section 1280 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.	E 000		
E 485	T22 DIV5 CH1 ART3-70263(g)(2) Pharmaceutical Service General Requirements (2) Medications and treatments shall be administered as ordered. This RULE: Is not met as evidenced by: Based on review of Patient I's clinical record, review of facility documents, and interviews with facility staff, the facility failed to ensure soft restraints were applied to a patient's wrists as ordered by the physician. This failure resulted in self extubation of the tracheostomy tube by Patient 1, thereby removing the direct access to	E 485	Nursing staff have been in-serviced on following physician orders particularly related to restraints and following policy and procedure on use of restraints (See attachment A). Respiratory Therapists and nursing staff have been in-serviced on tracheostomy tube changes, capping and de-cannulation (See attachment B). To ensure compliance, nursing administration will monitor restraint use and report findings quarterly to the hospital's Quality Council Committee.	6/18/09

LOS ANGELES COUNTY HEALTH FACILITIES DIVISION
2009 NOV -3 AM 9:28

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

Mike Sadri — Sup Hospital Operations — 11/3/09

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E 485	Continued From Page 1 provide an airway/oxygen to the patient's lungs. Patient 1 was subjected to a delay In airway management when Staff B failed to establish an open airway and administer oxygen immediately after discovering the patient pulled out his tracheostomy tube. A code blue was called, and during the cardiopulmonary resuscitation, the patient was found with no vital signs. Patient 1 subsequently expired due to cardio-respiratory arrest. Findings: On May 20, 2009, an unannounced visit was made to the facility to investigate a facility reported incident regarding the death of Patient 1 following self-extubation (removal of a tube from a hollow canal such as the trachea - windpipe). The clinical record for Patient 1 was reviewed on May 20, 2009. The History and Physical dated April 14, 2009, documented Patient 1 was admitted to the facility for pneumonia, with history of respiratory failure, and status post tracheostomy. (A tracheostomy is a surgically created opening in the neck leading directly to the trachea. It is maintained open with a hollow tube called a tracheostomy tube to provide an airway and to remove secretions from the lungs. Breathing is done through the tracheostomy tube rather than through the nose and mouth.) According to the interdisciplinary Progress Notes dated April 21, 2009 at 7:30 p.m., the patient had pulled out his tracheostomy tube, the tube was reinserted, and bilateral wrist restraints were applied to prevent pulling the tube out. The Interdisciplinary Progress Notes dated May 4, 2009 at 5:30 a.m., documented the patient tried to climb out of bed. There was no	E 485	The Respiratory Therapist (Staff B) was terminated and reported to the California State Respiratory Board (See attachment C). The position responsible for monitoring compliance will be the Chief Nursing Officer.	

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E 485	Continued From Page 2 documentation of restraints being applied, After 30 minutes, the patient "decannulated" (removed the cannula - tube) himself, was found by RT (respiratory therapist) holding his Inner cannula, the cannula was replaced by RT, and the restraints were applied for patient safety. A review of the Physician's Order Sheet dated May 4, 2009 at 7 a.m., Indicated an order for soft wrist restraints for patient safety to prevent harm to self. The Physician's Order Sheet dated May 5, 2009 at 10 a.m. indicated an order for soft wrist restraints. According to the facility's restraint policy end procedure dated March 2000, the physical restraint is a manual method of a physical or mechanical device, material or equipment that is attached to the patient's body that he or she cannot easily remove. The use of restraints required a physician's order and they were to be used when necessary to prevent injury to the patients. A review of the Interdisciplinary Progress Notes dated May 5, 2009, revealed the following: At 8 a.m., Patient 1 was awake, confused, followed simple commands, and was on "T-bar with 40% oxygen." (a "T-Bar' is a plastic tubing to connect oxygen to the tracheostomy site). The patient had soft restraints on "both upper extremities." At 12 p.m., the patient tried to move out of his restraints and the restraints were "reinforced." At 3:20 p.m., the patient was sleeping comfortably. There was no documentation in the progress notes if the restraints were applied at that time. At 3:30 p.m., the RT asked the assigned licensed nurse to check the patient. The	E 485		

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E 485	Continued From Page 3 assigned licensed nurse went to the patient's room and found the patient was pale and the inner cannula was out. The RT informed the licensed nurse that the cannula was in the patient's hand. The RT handed the licensed nurse the cannula and the licensed nurse told the RT to re-insert It back into the patient. Subsequent to the incident that occurred on May 5, 2009 at 3:30 p.m., the Respiratory Care Services Therapy Record dated May 5, 2009 at 3:30 p.m., documented "Treatment not done. Patient coded. Patient expired. Pronounced dead by the emergency room physician," There was no documentation of the respiratory therapist's assessment or observation of the patient. According to the Cardiopulmonary Resuscitation Record dated May 5, 2009 at 3:30 p.m., the patient was described as non-responsive and the initial rhythm was asystole (no heart beat, no rhythm on the cardiac monitor). The patient's blood pressure, heartbeat, respiration, and consciousness were not restored. The physician progress notes dated May 5, 2009 at 4 p.m., indicated the physician responded to a Code Blue at 3:36 p.m., (a Code Blue Is called when a patient is In cardiopulmonary arrest). Patient I was found to be in asystole without vitals signs (no pulse, no blood pressure). The patient did not respond to cardiopulmonary resuscitation and was pronounced dead at 3:53 p.m. The patient had a cardio-respiratory arrest. During an interview on May 20, 2009 at 1140 a.m., Staff A stated that on May 5, 2009 at approximately 3:30 p.m., Staff B (Respiratory Therapist) went to the Nurses' Station and asked Staff A who was the nurse assigned to Patient 1. Staff A stated she was the nurse for Patient 1.	E 485		

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E 485	Continued From Page 4 Staff B then told Staff A to check the patient. When Staff A went into the patient's room, she found the patient had "decannulated" himself, and she was not able to find the cannula, Staff A stated the tracheostomy tube was out and she could see the hole (opening made in the neck). When Staff B entered the room, Staff A informed him she could not find the Inner cannula and he told her It was in the patient's hand. Staff A looked in the patient's hand, and did not find the cannula, and then Staff B handed her the cannula. Staff A stated she took the cannula from Staff B and was about to reinsert the tube when she remembered he was the respiratory therapist and asked him to put it back, Staff A stated while Staff B was trying to put the tube back, she assesses the patient and found he had no pulse. During the same Interview, Staff A stated that prior to the Incident, the patient had been changed ten minutes earlier and was asleep at 3:20 p.m. Staff A stated the restraints were put back on the patient after he was cleaned. Staff A described the patient as restless and confused, However, a review of the restraint flow sheet dated May 5, 2009 at 3 p.m., revealed no documentation the patient had restraints applied to his wrists, as required by the physician's order During an Interview on May 20, 2009, at 12:25 p.m., Staff C stated when a patient pulled out the tracheostomy tube, "it was a common sense to put the tube back." In an Interview with Staff D on May 21, 2009, at 10:28 a.m., she stated for self-extubation with tracheostomy tube, the practice was to re-Insert the tube, check to make sure the patient was breathing, bag the patient with mask if unable to re-insert the tube, yell out for help, and do not leave the patient.	E 485		

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E 485	Continued From Page 5 On May 21, 2009 at 9:40 a.m., during an interview, Administrative 3 stated the patient had no restraints on At the time of the incident, otherwise it would have been reported to the Department as a patient death while in restraints. The facility's failure to ensure the restraints were applied as ordered by the physician resulted in self-extubation of the tracheostomy tube by Patient 1 thereby removing the direct access to provide an airway/oxygen to the patient's lungs. Additionally, Patient 1 was subjected to a delay In airway management when Staff B failed to establish an open airway and administer oxygen Immediately after finding the patient had pulled out his tracheostomy tube. A code blue was called, and during the cardiopulmonary resuscitation, the patient was found with no vital signs. Patient 1 subsequently expired due to cardio respiratory arrest.	E 485		