CAN

State of California - Health and Human Services Agency

Department of Public Health

1230 p
430 p

SECTION 1424 NOTICE

CITATION NUMBER: 91-1083-0006173-S

Date: 07/28/2009 Time:

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Type of Visit : Complaint Investig.
Incident/Complaint No.(s) : CA00163886, CA00170718

Licensee Name: Grancare, LLC

Address: ONE RAVINIA DRIVE, SUITE 1250 ATLANTA, GA 30346

License Number: 910000154 Type of Ownership: Limited Liability Company

HEAD-
ENTO-

Facility Name: ARBOR VIEW REHABILITATION AND WELLNESS CENTER
Address: 1338 20TH STREET SANTA MONICA, CA 90404
Telephone: (310)255-2800
Facility Type: Skilled Nursing Facility Capacity: 144
Facility ID: 910000336

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $100,000.00	DEADLINE FOR COMPLIANCE 7/28/09 11:59 p.m.

72523(c)(2)(A)

CLASS AA **CITATION -- PATIENT CARE**

72523. Patient Care Policies and Procedures
(c) Each facility shall establish and implement policies and procedures, including but not limited to:
(2) Nursing services policies and procedures which include:
(A) A current nursing procedure manual.

On October 2, 2008 at 12:05 am, an unannounced visit was made to the facility to investigate a complaint regarding patient care.

Based on interview and record review, the facility failed to implement its policy and current nursing procedure to ensure Patient A who was fed by a gastrostomy tube (GT) received treatment and services to prevent the dislodged tube and fluids from going into the abdominal cavity.

(1) According to the acute care hospital records, Patient A had a percutaneous endoscopic gastrostomy tube (PEG) inserted on August 29, 2008. On September 8, 2008, while in the skilled nursing facility, the tube was dislodged and was reinserted incorrectly by LVN 1. A computed tomography scan dated September 9, 2008, indicated the tube went into the abdominal cavity and not in the stomach causing inflammation of the lining of her abdominal cavity. The patient died on October 24, 2008 and the death certificate revealed the immediate cause of death was arteriosclerotic cardiovascular disease with the significant condition of peritonitis following

Name of Evaluator:
Barbara Vealy
HFEN I

Evaluator Signature : for B.V. HFEN

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature : Rebecca Forrest
Name : Rebecca FORREST
Title : Administrator

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

malpositioning of the gastrostomy tube.

(2) The facility's policy incicated the licensed nurse can only reinsert a GT that had been in place for three months or more. The post GT care from the acute hospital indicated if the GT falls out, place the tube back into the stoma (the opening) and arrange for radiology to replace the GT.

(3) According to American Society for Gastrointestinal Endoscopy (www.asge.org) PEG is a procedure through which a flexible feeding tube is placed through the abdominal wall and into the stomach. It allows nutrition, fluids and/or medications to be put directly into the stomach, by passing the mouth and esophagus. The PEG tract maturation usually occurs within the first 7-10 days. A PEG tube that is accidentally removed during this period should be replaced endoscopically, as the tract may be immature and the stomach and anterior abdominal wall can separate from each other, resulting in perforation (Practical Gastroenterology, November 2004 pp 73).

A review of the face sheet indicated Patient A was an 88 year old female who was readmitted to the facility from the acute care hospital on September 3, 2008, with diagnoses that included dysphagia, congested heart failure, cardiac dysrhythmias, chronic airway obstruction, hypertension and dementia. A review of the acute care hospital record indicated the patient had a PEG placement on August 29, 2008.

A review of the Minimum Data Set (MDS) full assessment dated September 8, 2008, indicated the Patient had short term memory problems, modified independence cognitive skills for daily decision-making, required extensive assistance with bed mobility, dressing and personal hygiene and totally dependent on staff for transferring, eating and was fed by a feeding tube. The MDS also indicated the Patient's acute medical condition would be monitored. The plan of care did not indicate the frequency of monitoring the resident's medical condition.

The physician's order dated September 3, 2008, indicated the Patient had the following feeding formula and medications to be administered by GT:

1. Nutren 1.0 at 35cc per hour by enteral pump for 20 hours. There was no intake and output record.
2. Prednisone 10 milligrams (mg) 1 tablet daily by GT and Prednisone 5 mg by GT daily for 1 week.
3. Lasix 80 mg 1 tablet by GT every morning.

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4. Digoxin 0.0625 mg by GT daily
5. Coreg 12.5 mg 1 tablet twice a day by GT.
6. Atounstatin 10 mg 1 tablet by GT at bedtime
7. Fish oil 1 gram via GT daily
8. Folate 1 mg 1 tablet by GT daily
9. Vitamin D 400 international unit (IU) 1 tablet by GT twice a day.
10. Doss 200mg by GT daily
11. Senna 2 tablets by GT at bedtime
12. Vitamin C 500 mg 1 tablet by GT daily
13. Aspirin 81 mg 1 tablet by GT daily
14. Flush the GT with 150 cc of water every six-hour and flush with 50 cc of water before and after medication administration every shift.

A review of the medication administration record (MAR) for the month of September 2008 revealed the Patient had received the above feeding formula and medications from September 3, 2008 until the evening of September 9, 2008 (6 days).

A review of the licensed nurses progress notes dated September 7, 2008 at 8 p.m., indicated the patient was noted to have discomfort during medication administration and water flushes. The physician was there and re-assessed the GT that was placed on August 29, 2008 and found there was no bleeding.

A review of the Daily Medicare Notes dated September 8, 2008, on the evening shift (no specific time) indicated the physician gave an order for the treatment nurse to remove the stitches from the skin disk on the GT due to skin irritation. During medication administration, the licensed nurse noticed the GT was displaced and the balloon was deflated. The Registered Nurse (RN) supervisor was notified and immediately secured the site with a new GT port to prevent closure of the site. The physician was called and gave an order to reinsert a new 20 French GT. The licensed nurse documented that the placement of the GT was checked and verified. There was no documentation to indicate the method of how the GT was checked for placement and if there was any residual, before administering pain medication. The licensed nurse documented that the GT was flushing well and continued with the Nutren 1.0 at 35cc per hour via enteral feeding pump.

Review of the licensed nursing notes dated September 9, 2008 at 5 pm, indicated the physician examined the Patient due to complaints of nausea and vomiting and not

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feeling well. The blood pressure was 77/51, temperature 98.9, respiratory rate of 18 and pulse rate of 89 beats per minute. The patient's abdomen was distended and tender to touch. The GT site had slight redness and leakage of the GT feeding formula. The physician ordered the patient to be transferred to the emergency room for evaluation.

A review of the acute hospital history and physical (H&P) dated September 9, 2008 at 10:39 p.m., indicated while the patient was in the skilled nursing facility, the sutures on/around the PEG were removed on September 8, 2008 and the tube was dislodged. The licensed nurse at the skilled nursing facility reinserted a new GT tube and continued with the tube feeding. The patient's tube feedings and medications were provided through the GT and the tube was not in place. A Computed Tomography (CT) scan of the abdomen and pelvis was obtained on September 9, 2008, which demonstrated that the GT dislodged, and the intra-abdominal cavity had massive amounts of ascites (fluid) which are likely to be tube feeding that had spilled into the peritoneum (the membrane that lines the abdominal cavity and covers most of the abdominal organs).

A review of the pathology (autopsy) report dated November 3, 2008, indicated Patient A passed away due to complications of inflammation of the lining of her abdominal cavity.

The certification of death dated October 24, 2008, revealed the immediate cause of death was arteriosclerotic cardiovascular disease with significant conditions contributing of peritonitis following malpositioning of gastrostomy.

The facility's policy titled, "Gastrointestinal Tube Change & Reinsertion Gastrointestinal Tube Change & Reinsertion" dated May 15, 2002, indicated the licensed nurse can change or reinsert GT in patients with an established tracts (in place 3 months or more) to maintain potency for nutritional needs.

A review of the post GT tube placement care dated August 29, 2008, (obtained from the acute care hospital) indicated the sutures can be removed in 21 days after the GT insertion. If the tube falls out, place the tube back in the stoma (the opening) and arrange for radiology to replace the GT. A request was made to medical records at the skilled nursing facility for post operative instructions and information was not available

On October 1, 2008 at 1:30 p.m., during an interview, the family member stated the Patient was doing well until the nurse removed and reinserted a new GT in the wrong

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	place causing the Patient to be transferred to the acute hospital. During an interview on October 2, 2008 at 2 p.m., the director of nursing stated she was new to the facility. She also stated she did not know too much about the incident. The DON stated that LVN 1 was no longer working at the facility and was not available for an interview. The facility failed to implement its policy and current nursing procedure to ensure Patient A who was fed by a gastrostomy tube (GT) received treatment and services to prevent the dislodged tube and fluids from going into the abdominal cavity. The above violation was a direct proximate cause of death of Patient A.