

Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2006
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NAME OF PROVIDER OR SUPPLIER NOVATO COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 180 ROWLAND WAY NOVATO, CA 94945
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E 000	Initial Comments The following reflects the findings of the California Department of Health Services during a COMPLAINT VISIT CA:00065467. Investigation was limited to the specific complaint and does not represent the findings of a full inspection of the facility. Representing the California Department of Health Services: Mary E.Becker, HFEN	E 000		
E 290	T22 DIV5 CH1 ART3-70215(a) Planning and Implementing Patient Care (a) A registered nurse shall directly provide: This Statute is not met as evidenced by:	E 290	70215(a)(1) Novato Community Hospital agrees to comply with its Continuous Cardiac Monitoring clinical policy <u>Plan of Correction:</u> 1. The hospital policy on Continuous Cardiac Monitoring shall be revised to include a reliable notification system when a patient on telemetry monitoring becomes disconnected.	11/30/05
E 291	T22 DIV5 CH1 ART3-70215(a)(1) Planning and Implementing Patient Care (a) A registered nurse shall directly provide: (1) Ongoing patient assessments as defined in the Business and Professions Code, Section 2725(d). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area. This Statute is not met as evidenced by: Based on medical record review, observation, and staff interview, the facility failed to ensure	E 291	2. The Medical/Surgical and Critical Care staff will shall be trained on notification process and timely response to patients who become disconnected from the telemetry system. 3. A review of the Medical/Surgical unit staff on response time to a telemetry disconnection will take place to determine compliance with policy. <u>Person Responsible:</u> Director of Patient Care Services	11/30/05 11/30/05

icensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Assistant Administrator* (X6) DATE: *2/23/07*

STATE FORM 6899 OJSF11 If continuation sheet 1 of 4
POC accepted 2/27/07 by Becker HFEN

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E 291	<p>Continued From page 1</p> <p>that the registered nurse provided ongoing assessments of Patient A, with a history of myocardial infarction (MI - heart attack), when the cardiac monitor alarmed indicating the patient's heart rhythm was not being monitored and requiring an assessment of the patient's condition.</p> <p>Findings:</p> <p>Medical record review on 2/7/06 for Patient A revealed the patient was admitted on 1/23/05 with the diagnoses; MI (which was an extensive subendocardial MI), congestive heart failure, ventricular dysrhythmias (abnormal cardiac rhythm), chronic renal insufficiency, and upper gastrointestinal bleed. Patient A arrived in the Emergency Department (ED) in moderately severe distress, and was admitted to the ICU for further care, according to the ED note of 1/23/05. On 1/28/05 the physician ordered the patient to be transferred from ICU to the medical surgical unit and to be on telemetry (monitoring of the cardiac status from another location in the facility).</p> <p>The Medical Surgical unit was toured and observed on 2/7/06. Patient A had been in bed 202B. This bed was farthest from the door. The bathroom was closest to the door leading into the hallway and area with the nurses' station. The Physician's progress notes of 1/29/05 document that Patient A, "had an episode of nonsustained Ventricular Tachycardia (rapid heartbeat) in the morning. He was asymptomatic. However, at 10:47 a.m. the cardiac monitor went from normal sinus rhythm to no signal." The physician continued in the progress note, that Patient A was, "found down by the bed without a pulse. Attempts to resuscitate the patient were</p>	E 291		

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E 291	<p>Continued From page 2</p> <p>unsuccessful. The cause of death was ventricular dysrhythmia due to recent M.I."</p> <p>In the Discharge Summary which was dictated 1/29/05 and signed 1/31/05, the physician documents, "At 1047 on the final hospital day, his (Patient A) monitor was noted to go from normal sinus rhythm to no signal. When the nursing staff went to check on the patient subsequently, he was initially felt to be in the bathroom but was subsequently discover (sic) on the floor by the side of his bedand to be in asystole (no heart beat). Attempts of resuscitation were unsuccessful ...the presumed fatal ventricular dysrhythmia was not documented due to the monitor not being in place-whether due to fall or patient removal."</p> <p>During interview on 2/7/06, Nurse 2 stated that he had called the Med-Surg unit two times the morning of 1/29/05, while caring for his own patient in ICU, to inform staff that Patient A was, "off telemetry," (monitor off or disconnected). When the monitor screen in ICU kept showing that Patient A was still off the monitor, Nurse 2 left his patient in the care of another nurse in ICU and walked over to the Med-Surg unit to tell Nurse 3 (the team leader on Med-Surg) that Patient A was still off the monitor. Nurse 3 was outside the Patient A's room talking to Nurse 4 (the nurse assigned to Patient A's care), in response Nurse 3 and 4 stated, "(Patient A) is not in his room." Nurse 3 was interviewed on 2/7/06 and stated that she checked the bathroom and Patient A was not there, she then asked Nurse 4, "Where is your patient?" Nurse 3 found Patient A on the floor beside the bed; he had fallen there and looked blue."</p> <p>Nursing staff for Patient A failed to provide the</p>	E 291		

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E 291	Continued From page 3 ongoing patient assessments as required when informed two times by the ICU staff on the morning of 1/29/05 that Patient A's cardiac rhythm was not showing on the monitor screen in ICU. Nurse 2 had to leave his patients in ICU and go to the Med-Surg department, in order to ascertain the condition of Patient A. The nursing staff assigned to Patient A failed to assess Patient A's condition and had assumed that he was in the bathroom, when in fact, he had fallen on the floor on the side of the bed away from the door leading into room 202B and could not be seen from the doorway by staff.	E 291		