

SECTION 1424 NOTICE
 CITATION NUMBER: 05-1371-0001618-8

Page: 1 of 5 pages
 Date: 01/10/2005 Time: 10:10am

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

Type of Visit: COMPLAINT
 Complaint Number(s): CA00030318

Licensee Name: MERIDIAN NEURO CARE, LLC
 Address: 18-A JOURNEY, ALISO VIEJO CA 92656
 License Number: 56-0000384 Type of ownership: LTD. LIABILITY CO.

Facility Name: CAREMERIDIAN
 Address: 1540 TEAL CLUB ROAD OXNARD CA 93030
 Telephone: (805) 382-1921
 Type: 22 CONGREGATE LIVING HEALTH Capacity: 10
 ACLAIMS ID: 05-00953

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT	DEADLINE FOR COMPLIANCE
Title 22, CCR 72311(a)(1)(A)	<p>CLASS AA CITATION -- PATIENT CARE</p> <p>72311. Nursing Service--General (a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission.</p> <p>The facility did not comply with the above regulation by failing to identify a patient's care needs based upon a continuing assessment. On June 2, 2004 a nurse replaced Patient A's gastrostomy tube (G-tube). Facility nurses administered formula and water through the G-tube without</p>	\$25,000.00	01/17/2005 0800 a.m.

Name of Evaluator:
 Lori Dulek
 HFE-N

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

Signature: *[Handwritten Signature]*

Name: Thomas L. White

Title: Acting D.D.V.

Evaluator Signature: Lori Dulek
 HFE-N

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

MR-ACL221-R001 (1/99)

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	<p>verifying correct placement, and in the presence of findings indicating that the tube was not in the patient's stomach. The patient expired approximately 12 hours following the replacement of his G-tube. An autopsy was performed and revealed the patient's cause of death as peritonitis resulting from formula and water introduced into his abdominal cavity through the G-tube.</p> <p>Patient A was a 20 year old male who was admitted to the facility on January 20, 2004 with diagnoses including anoxic brain injury. The patient was comatose, and received his nutrition, hydration and medications through a gastrostomy tube (tube extending through a surgical opening in the abdominal wall into the stomach). On May 28, 2004 the patient underwent a diagnostic endoscopic procedure at a local hospital. During the procedure, the physician visualized the patient's stomach and the tube and confirmed correct placement of the G-tube in the patient's stomach.</p> <p>Following the procedure, the patient did not experience any problems related to his G-tube until 3:00 am on June 2, 2004, when a nurse documented that the patient's G-tube had come out. Nurse 1 documented that she inserted a "#20, 7cc Mickey G-tube PEG (percutaneous gastrostomy tube)," and "Placement correct x 2." Although the nurse's note indicated "Scheduled feeding tolerated," further documentation reflected that she administered the medications Ativan and ibuprofen to the patient through his G-tube for "increased agitation" and "noted discomfort" following reinsertion of the tube.</p> <p>It is of critical importance to verify that a G-tube is in the stomach before accessing the tube for feeding, medications or hydration, as misplacement of the tube outside the stomach can result in life-threatening complications, such as peritonitis. Correct placement is most accurately confirmed through x-ray or fluoroscopic examination. Assessment techniques used at the bedside to verify correct tube placement include aspiration and auscultation.</p> <p>Aspiration involves the withdrawal of stomach contents with a syringe. The absence of gastric aspirate is an abnormal finding and an indication that the tube is not in the stomach. Auscultation is a less reliable method that is usually used in conjunction with aspiration, to check placement. Auscultation involves injecting a small amount of air into the tube and listening for a "whooshing" sound through a stethoscope positioned against the abdomen.</p> <p>During an interview on November 5, 2004, Nurse 1 indicated that she used the auscultation method twice after replacing the tube and before administering the patient's feeding. In addition, Nurse 1 indicated that she checked for residual</p>

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	<p>and did not get any residual or gastric contents upon aspiration. The nurse interpreted this to mean that the patient had absorbed all of his last feeding and was ready for his next feeding. Nurse 1 failed to recognize that the absence of gastric aspirate was an abnormal finding, and an indication that the tube was not in the patient's stomach, and administered two feedings, water flushes and medication to the patient through his G-tube between 3:00 am and 7:00 am.</p> <p>At 7:00 am Nurse 2 noted that both of Patient A's eyes were open, that his skin was moist and that he was sweating a large amount. Vital signs taken by a CNA at 7:32 am revealed that Patient A's axillary temperature was slightly elevated at 98.7 degrees, and his pulse, respirations and blood pressure were elevated at 117 (normal range 60-100), 24 (normal range 12-20) and 140/80 (reference normal 120/80), respectively.</p> <p>In an interview with Nurse 2, she stated that she started the patient's 9:00 am feeding while he was lying in bed. Although Nurse 2 revealed that Patient A's morning feeding "usually goes right down," she indicated that the feeding "went down slow" on June 2, 2004. Nurse 2 indicated that she stopped the feeding until staff was able to place the patient in a more upright position on the tilt table. Nurse 2 confirmed that she did not obtain any gastric contents or residual upon aspiration, prior to starting the feeding. According to Nurse 2, the absence of residual indicated that the patient was not full, and that is was "ok to feed him."</p> <p>The Certified Nursing Assistant (CNA) who cared for Patient A on the morning of June 2, 2004 was interviewed and stated that the patient was not doing well that day and that "something was different." According to the CNA, routine vital signs are taken at the beginning of each shift, but she took Patient A's vital signs again between 11:45 am and 12:30 pm, because he "looked different," and was pale and sweaty. She informed Nurse 2 that the patient's temperature was 101.7 degrees and that she was unable to obtain his blood pressure, despite 3 attempts.</p> <p>At 1:30 pm Nurse 2 documented that Patient A's temperature was 101.2, his eyes were open and his skin was pale and moist. At 1:45 pm the nurse noted that the patient was "sweating profusely" and the Director of Nurses was called to the bedside. Repeat vital signs documented at 2:00 pm noted an elevated axillary temperature of 101.4 degrees, an oxygen saturation of 84% (>90=normal), rapid respirations at 40 breaths per minute and a decreased heart rate of 40 beats per minute.</p> <p>According to her notes, Nurse 2 contacted the physician's office at 2:15 pm to report the change in the patient's</p>

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	<p>condition. An entry at 2:30 pm reflected that the physician called, instructed her to call an ambulance and have the patient transported to the hospital and that the ambulance was at the facility. The ambulance report, however, indicated that the ambulance was dispatched to the facility at 3:21 pm and arrived 3:29 pm. According to the ambulance report, the patient was unresponsive, was not breathing and was without a pulse upon arrival, and he was pronounced dead at 3:30 pm.</p> <p>An autopsy was performed and revealed that Patient A's gastrostomy tube was not in his stomach and the end of the tube was feeding liquid directly into the peritoneal (abdominal) cavity. The report noted approximately 2500cc of opaque yellow fluid in the patient's abdominal cavity, an amount directly correlating with the volume of formula and water administered to the patient by Nurse 1 and Nurse 2 following the replacement of his G-tube approximately twelve hours before his death.</p> <p>Patient A's death certificate noted that he died on June 2, 2004 at 3:30 pm due to peritonitis (inflammation of the membrane lining the abdominal cavity) caused by infusion of feeding into the peritoneal cavity, caused by malposition of a gastrostomy tube. In an interview on October 22, 2004, the Coroner confirmed that the patient's G-tube was not in his stomach. The Coroner revealed that the nurse who replaced the tube at 3:00 am on June 2, 2004 would not have obtained gastric contents or residual if she attempted to verify correct placement of the tube using aspiration. Additionally, the Coroner indicated that the inflammatory process as observed during autopsy had started just hours prior to Patient A's death.</p> <p>Patient A's physician was interviewed on October 27, 2004 and revealed that he was present at the autopsy, and he confirmed that the patient's G-tube was in his peritoneum, not in his stomach. According to the physician, the tube was not correctly placed when inserted by facility staff on June 2, 2004. The physician explained that he could come to no other conclusion since the patient's tube and stomach were directly visualized by a gastroenterologist five days before his death and the tube was in the patient's stomach at that time.</p> <p>The facility is in violation of the above regulation by its failure to continuously assess and identify Patient A's care needs after the replacement of his feeding tube on June 2, 2004. Facility nurses administered formula and water through the G-tube without verifying correct placement and in the presence of findings indicating that the tube was not in the patient's stomach. Patient A expired as a result of peritonitis approximately twelve hours after the nurse replaced the tube and facility staff administered water and</p>

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	<p>formula through the misplaced tube into the patient's abdominal cavity.</p> <p>The facility's failure presented either imminent danger that death or serious harm would result or substantial probability that death or serious physical harm would result and was a direct proximate cause of the patient's death.</p>

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MR-ACL221-R001 (1/99)

CIVIL MONEY PENALTY ASSESSMENT
Facility: CAREMERIDIAN

DATE	CITATION #	CLASS	PENALTY ASSESSED	TOTAL DUE
01/10/2005	05-1371-0001618-S	AA	\$25,000.00	\$25,000.00
SECTION(S) VIOLATED				
72311(a)(1)(A)				

This citation has been issued as a Class AA.

Full Payment Due by: 02/09/2005

PAYMENT OPTIONS

Per Health and Safety Code, Section 1428.1, licensee may pay 65% of the amount shown above in "Total Due" within 15 business days after service of this citation, or the minimum amount defined by law, whichever is greater in lieu of contesting the citation (Class AA Citation penalty minimum amount defined by law is \$5,000). If licensee chooses not to exercise the 65%/15 business day option, the full amount is due.

MAKE CHECK PAYABLE TO:
 Department of Health Services
 Include Citation Number

MAILING ADDRESS:
 Licensing and Certification
 Centralized Citation Collection Unit
 P.O. Box 189190
 Sacramento, CA 95818-9190
 (916) 552-8726

COLLECTION OF DELINQUENT PAYMENTS

MS will pursue collection of delinquent payments, including, but not limited to Medi-Cal offset (per Health & Safety Code, Section 1428). This will result in withholding of the licensee's Medi-Cal payments until the full amount of the citation is collected. In order to present a valid objection to the use of Medi-Cal offset, please contact the Centralized Citation Collection Unit at the address listed above.

CONTESTING A CLASS "AA" CITATION

A licensee may contest a citation or penalty assessment (per Health & Safety Code, Section 1428) at a Citation Review Conference (CRC), or by directly filing an action in municipal or superior court.

To contest, a licensee must send a written request for a CRC or the intent to adjudicate the validity of the citation in court (per Health & Safety Code, Section 1428). The written request must be sent to the district office issuing the citation and must be postmarked within fifteen (15) business days after service of this citation. Please submit written request to:

Department of Health Services
 Licensing & Certification Program
 Ventura District Office
 1889 N. Rice Ave., Suite 200
 Oxnard, CA 93036

Mary Hernandez

 Signature of Licensing District Administrator/Designee

January 18, 2002 (Revised)

1.10.05

 Date