

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 056327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/07/2016
NAME OF PROVIDER OF SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - WALNUT CREEK		STREET ADDRESS, CITY, STATE, ZIP 1224 ROSSMOOR PARKWAY WALNUT CREEK, CA 94595	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG F 0328	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
Level of harm - Actual harm Residents Affected - Few	<p>Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on interview and record review the facility failed to provide the proper [MEDICAL CONDITION] treatment and care for Resident 1, by not following their own policy and procedure for [MEDICAL CONDITION] change and failed to provide effective resuscitation for an unsuccessful [MEDICAL CONDITION] change.</p> <p>This failure resulted in Resident 1's subsequent death.</p> <p>Definitions: [MEDICAL CONDITION]: a surgical opening through the neck into the trachea (windpipe) to allow for mechanical breathing in patients with [MEDICAL CONDITION]. [MEDICAL CONDITION] cuff: a balloon that seals off the space between the wall of the trachea and [MEDICAL CONDITION]. Subcutaneous Tissue [MEDICAL CONDITION]: air trapped under the skin. Stoma: an artificial opening in the neck area to allow for the [MEDICAL CONDITION]. Hyperextend: to extend beyond the normal range of motion. Oxygen saturation level: O2 sat- a measurement of oxygen concentration in the blood. Crepitus: A clinical sign characterized by a crackling or popping sound of air in the soft tissue around the lungs in an area where it should not be.</p> <p>Findings: Review of the clinical record showed Resident 1 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident 1 had a [MEDICAL CONDITION] and was dependent on a ventilator (a breathing machine).</p> <p>On 10/28/15 The Director of Respiratory Therapy (DRT), Respiratory Therapist (RT) 1, RT 2, and Medical Doctor (MD) 1 performed a scheduled [MEDICAL CONDITION] change ordered for Resident 1. DRT documented vital signs for Resident 1's prior to the [MEDICAL CONDITION] change as followed: oxygen saturation level 99% (normal: 95-100%), heart rate was 73 beats/minute (normal: 60-100), respiratory rate was 14 breaths/minute (normal: 10-20), RT 2 stated Resident 1 did not have any respiratory issues prior to the [MEDICAL CONDITION] change.</p> <p>Review of facility's policy and procedures [MEDICAL CONDITION] change, revised on 10/31/08 indicated to, Hyperextend the resident's neck by placing a folded towel under the neck. Inflate the [MEDICAL CONDITION] cuff, if physician ordered: a. Fill syringe with 10 ml of air, and attach to cuff inflation port. b. Place stethoscope over trachea. c. Slowly inflate the cuff until no airflow is heard during inspiration. d. Slightly deflate the cuff until a minimal amount of airflow is heard. According to the Science Journal of the American Association for Respiratory Care: When to change a [MEDICAL CONDITION], dated 8/2010 indicated, Failure to replace the [MEDICAL CONDITION] at the time of a routine change can rapidly create an emergency with loss of the airway. Figure 10 shows a suggested algorithm (a process) to help guide practitioners when this occurs. The algorithm to Figure 10 indicated the following: Failed [MEDICAL CONDITION] change > Adequate oxygenation and ventilation? > No > Supplemental oxygen, oral bag-mask ventilation. Reference (http://rc.rcjournal.com/content/55/8/1056.full.pdf.html)</p> <p>In an interview on 11/9/15 at 8:48 a.m., DRT confirmed Resident 1 was placed in a semi-fowler's position (a position with the head of the bed elevated approximately 30 to 45 degrees) with Resident 1's neck extended. DRT stated Resident 1's stoma was patent and opened as he withdrew the old [MEDICAL CONDITION]. DRT stated he met resistance when he inserted Resident 1's new [MEDICAL CONDITION]. DRT stated 15 seconds after he connected Resident 1's [MEDICAL CONDITION] to the ventilator, Resident 1's condition changed. DRT stated Resident 1's oxygen saturations decreased, Resident 1's heart rate was above 100 (60 to 100 beats per minute is normal), subcutaneous tissue [MEDICAL CONDITION] was noted on the left side of Resident 1's neck, and Resident 1's lungs felt tight. DRT stated he deflated Resident 1's [MEDICAL CONDITION] cuff and attempted to realign Resident 1's [MEDICAL CONDITION] by backing it out, but he did not take the [MEDICAL CONDITION] completely out. DRT stated Resident 1's oxygen saturation levels went up and down. DRT stated he ventilated Resident 1 via Resident 1's [MEDICAL CONDITION] with a bag-valve mask (BVM, a hand-held, manual, self-inflating bag used to provide ventilation) until the paramedics arrived.</p> <p>In an interview on 11/9/15 at 9:40 a.m., RT 1 confirmed Resident 1's skin color on her face turned to ashy color and her oxygen saturation levels dropped and fluctuated between 58 to 80% after the [MEDICAL CONDITION] change.</p> <p>In an interview on 11/18/15 at 10:45 a.m., RT 2 stated moments after Resident 1's [MEDICAL CONDITION] was attached to the ventilator, Resident 1 developed subcutaneous tissue [MEDICAL CONDITION] on the left side of her neck and her skin changed to greyish-blue, dusky. RT 2 confirmed Resident 1 had diminished breath sounds in the left lung after the [MEDICAL CONDITION] change. RT 2 confirmed Resident 1's skin color remained dusky when Resident 1 was taken to the hospital by paramedics. RT 2 stated Resident 1's [MEDICAL CONDITION] could have been misplaced during the [MEDICAL CONDITION] change.</p> <p>In a telephone interview on 11/18/15 at 11:45 a.m., RT 1 confirmed she had met resistance when she attempted to suction Resident 1 via the [MEDICAL CONDITION]. RT 1 stated there were scant, blood-tinged secretions when she tried to suction the [MEDICAL CONDITION]. RT 1 stated Resident 1's oxygen saturation levels were in the 80s and her heart rate was in the 120s after DRT manipulated and repositioned Resident 1's [MEDICAL CONDITION].</p> <p>In a telephone interview on 12/31/15 at 9:00 a.m., RT 2 stated a misalignment of a [MEDICAL CONDITION] would cause subcutaneous tissue [MEDICAL CONDITION] in the neck. RT 2 confirmed Resident 1 was ventilated with a BVM through the [MEDICAL CONDITION] and not through the mouth when subcutaneous tissue [MEDICAL CONDITION] was noted on the left side of Resident 1's neck.</p> <p>In a telephone interview on 12/31/15 at 9:20 a.m., RT 1 confirmed Resident 1 was ventilated with a BVM through the [MEDICAL CONDITION] and not through the mouth. RT 1 confirmed Resident 1 was placed in a semi-fowler's position with no support under the neck. RT 1 stated Resident 1 started to develop subcutaneous tissue [MEDICAL CONDITION] in the left neck area after her new [MEDICAL CONDITION] was inserted.</p> <p>In a telephone interview on 12/31/15 at 11:00 a.m., an Ears, Nose and Throat Doctor (ENT, an expert in [MEDICAL CONDITION] from the General Acute Care Hospital that treated Resident 1 in the emergency room) stated the best position to do a [MEDICAL CONDITION] change was to have a patient in a supine (flat on the back facing up) position with the neck extended and a towel placed under the neck, which would allow the neck to be more exposed visibly. The ENT stated to indicate if a [MEDICAL CONDITION] was placed correctly staff could pass a suction catheter through the [MEDICAL CONDITION] without resistance, and listen to both lungs for good air exchange. The ENT stated manipulating the [MEDICAL CONDITION] while still</p>		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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<p>Level of harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>(continued... from page 1)</p> <p>in the trachea would not help and may create a false passage. The ENT stated the [MEDICAL CONDITION] must be taken out and re-inserted with a smaller sized [MEDICAL CONDITION] if there were any problems in ventilation. The ENT stated covering the stoma and using a BVM via mouth was a way to properly ventilate someone in an emergency if ventilating via the [MEDICAL CONDITION] was not an option.</p> <p>In a telephone interview on 12/31/15 at 11:40 a.m., DRT stated there were no emergency protocols or policy and procedures in an event like this, only to call 911. DRT stated he did not feel comfortable to change the [MEDICAL CONDITION] to a smaller size. DRT confirmed he ventilated Resident 1 via the [MEDICAL CONDITION] and not by the mouth with a BVM.</p> <p>In an interview on 6/23/16 at 11:45 a.m., an Expert Respiratory Therapist Consultant (ERTC) from the Respiratory Care Board of California stated Resident 1 had the signs and symptoms (the low oxygen saturation, fast heartbeat, change in color of skin, the inability for RT 2 to suction via the [MEDICAL CONDITION], and the tissue [MEDICAL CONDITION]) that indicated her [MEDICAL CONDITION] was in the wrong place. Furthermore the ERTC stated the continuous resuscitation of Resident 1's [MEDICAL CONDITION] when not in the correct place would lead to oxygen not going to the lungs and into the tissue space, which would lead to subsequent death if not corrected. The ERTC stated the facility's staff should have recognized that Resident 1's [MEDICAL CONDITION] was not in the right place from the signs and symptoms that were present, and should have removed the [MEDICAL CONDITION], cover Resident 1's stoma and provided oxygen to Resident 1's mouth with a BVM.</p> <p>Record review of Progress notes, dated 10/28/15 by DRT showed, Upon insertion DRT met resistance approximately two inches into stoma. Clear (breath sounds) on the right (lung), diminished on the left (lung). Shortly after Resident 1's oxygen saturation levels began to drop. Resident 1 placed on 100% oxygen via BVM. Resident 1 had a change in color, absent breath sounds on the left. Heart rate in the 120s. MD 1 noticed crepitus (subcutaneous tissue [MEDICAL CONDITION]) around neck. Resident 1 suctioned several times, blood tinged secretions.</p> <p>Record review of MD 1's Progress Note dated 10/28/15 showed, Resident 1's [MEDICAL CONDITION] change got complicated with acute [MEDICAL CONDITION], RT 1 realigned the [MEDICAL CONDITION] and did multiple suction which were blood tinge for decrease oxygenation. Although her oxygen improved to the 90's initially and later fluctuated between 53-98%, also Resident 1 developed chest crepitus, 911 was called, started bagging (artificial respiration with a hand held air bag) and patient was transferred to acute care for [MEDICAL CONDITION](rapid ineffective heart beat) with decrease oxygen saturation (amount of oxygen in the blood).</p> <p>Record review of the Emergency Medical Technician-Paramedic Patient care report, dated 10/28/15 showed, Per RT upon insertion of new ([MEDICAL CONDITION]) tube resistance was met and blood was noted around stoma. Staff member states poor BVM compliance noted. RT states subcutaneous (tissue) [MEDICAL CONDITION] noted to left chest and believes [MEDICAL CONDITION] may be displaced. Skin temperature cool, Skin color cyanotic, left lung sounds absent, right lung sounds decreased, capillary refill (a quick test to indicate blood flow in the tissue) absent, level of consciousness unresponsive, heart rate 134, and oxygen saturations 70% with supplemental oxygen.</p> <p>Record review of Emergency Department (ED) nursing notes, dated 10/28/15 showed, Blood coming from [MEDICAL CONDITION].</p> <p>Crepitus around trachea. Resident 1 is mottled (spots or patches with different colors).</p> <p>Record review of the ED physician progress notes [REDACTED].(Resident 1) with emergent airway issue and prolonged anoxia (absence of oxygen) with apparent severe [MEDICAL CONDITION]. Unable to ventilate [MEDICAL CONDITION] place with subterranean air(crepitus) felt in surrounding tissue .Time of death 1:20 (pm).</p> <p>Record review of the Coroner's Report, dated 3/31/16 showed, Autopsy (an examination used to determine the cause of death) findings: Perforation (a hole made by piercing) of posterior wall of esophagus (throat) and trachea due to improper placement of [MEDICAL CONDITION], with tip of [MEDICAL CONDITION] impacting fifth cervical vertebra (the upper spine that form the neck). These findings are consistent with placement of the tube in the esophagus with perforation. There is also evidence of the [MEDICAL CONDITION] causing perforation of the trachea and entry of the tip of the tube into the lower esophagus. Cause of Death: Acute [MEDICAL CONDITION], with bilateral collapsed lungs, due to improper placement of [MEDICAL CONDITION], with tracheal and [MEDICAL CONDITION] perforation.</p>		