



Complaint Summary for Public Viewing Reports for:
SELECT SPECIALTY HOSPITAL-DENVER

Intake ID: CO00007862
Facility: SELECT SPECIALTY HOSPITAL-DENVER
Date of Complaint: 3/2/2006
Date of Investigation: 5/15/2006
Total Number of Allegations for Complaint: 7

Allegation: 1

Type: Quality of Care/Treatment

Findings: Unsubstantiated

Allegation Detail: The Health Facilities and Emergency Medical Services Division received a complaint on January 29, 2006. The complainant alleges that the facility failed to ensure that the patient received thickened liquids and pureed foods with feeding supervision to accommodate his swallowing disorder.

Findings Detail: An unannounced on-site survey, authorized by Centers for Medicare and Medicaid (CMS), was conducted by four surveyors from 5/16/06 through 5/17/06. Interviews were conducted, policies, procedures, medical records and personnel files were reviewed. Staffing schedules and incident reports were reviewed and observations were made. Areas of survey included: Nursing Services, Infection Control, Discharge Planning, Food and Dietetic Services and Patient Rights.

The medical record of the complaint, --- ----, was reviewed. The patient was admitted to the facility on --- ---- with diagnosis of --- ---- and was experiencing --- ----. The initial nutritional assessment on --- ---- revealed the patient was on a Dysphagia I diet which consisted of pureed foods and nectar thick liquids as well as tube feedings. According to nutritional assessment notes, the diet was upgraded to a mechanical soft which allowed chopped/ground meats due to the patient not liking the puree diet. However, the patient did not tolerate the upgrade in the diet and was pocketing foods. The diet was then changed to a mechanical soft ground with the nectar thick liquids. On --- ---- a physician order was written to "Hold PO (by mouth) diet." On --- ---- a physician order was written for "NPO (nothing by mouth)." According to nutritional documentation, the patient remained NPO until discharge with tube feedings as the only source of nutrition.

An interview was conducted with the registered dietitian (RD) on 5/17/06 regarding the processing of dietary orders. The RD stated that she inputs the dietary orders into a computer located on the nursing unit and immediately the order goes to the dietary office located adjacent to the kitchen. There the order is automatically printed and two dietary staff make certain the kitchen staff promptly receive it. Observations of the procedure were made at that time.

An interview was conducted with the director of clinical services --- ---- on 5/17/06. The

director stated that evaluating a patient for assistance in eating was a team effort. The nurses, certified nursing assistants (CNAs) and occupational therapists determine the need for assistance. Both the nurses and CNAs are involved in the assistance in eating . However, the director further stated that when assistance in eating has been given, it is not usually charted.

Further review of the medical record revealed documentation by a hospitalist on 11/16/05 which stated; --- ---- An hour later a physician order was written which read: "Please reinforce --- ---- that all liquids incl. soda, need to be thickened." According to an interview with the director of clinical services on 5/17/06, there was a misunderstanding about carbonated drinks not needing to be thickened. Further education was performed per physician order.

The allegations that the facility failed to ensure the patient received thickened liquids and pureed foods and failed to provide feeding supervision was not substantiated. No deficient practice was cited.

Allegation: 2

Type: Nursing Services

Findings: Unsubstantiated

Allegation Detail: The complainant alleges that the facility failed to ensure that the patient had assistance with eating to accommodate his swallowing disorder/choking risk.

Findings Detail: Please see previous allegation.

Allegation: 3

Type: Nursing Services

Findings: Substantiated

Allegation Detail: The complainant alleges that the facility failed to provide mouth care for the patient. The patient developed a hard crust on the back of his throat that effected his speech and swallowing, requiring a consultation with a swallowing specialist physician, who stated that the patient's "throat had to be scraped out."

Findings Detail: According to facility policy and procedure, "Standards of Care, Nursing", oral care for patients that were receiving tube feedings and were NPO (nothing passed orally) should have been performed "every 4 hours".

On 11/14/05, the patient's physician --- ---- wrote orders for the patient to receive mouth care four times a day. --- ---- The patient was NPO and received tube feedings.

On 11/26/05, the same physician --- ---- wrote orders for the patient to receive a specific type of mouth care --- ---- every 4 hours, for a total of 6 times per day. The phy-

sician's order specified that a registered nurse (RN) was to provide the mouth care at least twice each day and a certified nurse's aide could provide it at the other times. The patient was NPO and receiving tube feedings.

Review of nursing staff documentation of oral care provided to the patient, during his hospitalization, was conducted. There was a lack of documentation that demonstrated the facility followed their policy and procedure or physician's orders, throughout the patient's hospitalization.

The patient was receiving tube feedings on 10/5/06, the day the patient was admitted to the hospital. According to facility policy and procedure and physician's orders, documentation should have demonstrated that the patient received oral care/mouth care 6 times per day, during his hospitalization. However, documentation demonstrated the patient received oral care less frequently than he should have.

The patient was hospitalized a total of 64 days, not counting the day he was discharged. Documentation failed to demonstrate the patient received oral care according to facility policy, or physician's orders, for 64 days out of his 64-day hospitalization. --- ----

At the time of the survey, the facility had already identified this issue, had implemented a plan of correction, and was monitoring the results. --- ----

In summary, the facility failed to demonstrate that oral care was provided to the patient, according to facility policy and procedure or physician's orders. The facility had identified the issue and had implemented a plan of correction, prior to the survey.

The allegation was substantiated. No federal deficiencies were cited.

Allegation: 5

Type: Quality of Care/Treatment

Findings: Unsubstantiated

Allegation Detail: The complainant alleges that the facility staff failed to recognize the patient's change in level of consciousness was due to a very elevated blood sugar level.

The patient, a diabetic, was receiving an IV with glucose and family found him in an unresponsive state. His blood sugar was checked and found to be above 400. He was given insulin, which stabilized his condition.

Findings Detail: The patient was transferred from --- ---- and was sent to --- ---- for rehabilitation on 10/05/05. The --- ---- " History and Physical " revealed that the patient had a history of Diabetes Mellitus, type 2 and was maintained on long lasting insulin medication --- ---- throughout his hospitalization. The 74 year old patient had received antibiotics intravenously for an infection --- ---- and required nightly tube feedings for nutritional support.

On 10/17/05 at 8:45 am the RD (Registered Dietician) documented in the " Progress Notes "the physician requested a possible change in the TF (tube feeding) formula. It was documented the patient was having difficulty with oral fluids. An order was written on 10/17/05 to change TF --- ----. It was documented "this is a more concentrated DM (diabetes mellitus) formula and will provide less free water than the previous tube feeding formula so it may increase blood sugar levels " . Glucoscans, or blood sugar levels were routinely performed on the patient by nursing staff before meals and at bedtime.

The patient's nutritional status was assessed on an ongoing basis by the RD (registered dietician). On 10/24/05, the patient's diet was changed to mechanical soft with ground meat and nectar thick liquids. On 11/04/05, it was documented by the physician that the patient was " lethargic, one word answers " . The RD reported the " patient's po (oral) intake much improved during the day, eating 75-100% of meals, and eats really well when wife assists " . There was a new physician order on 11/04/05 for intravenous fluids which contained dextrose --- ----.

The patient experienced elevated temperatures and continued to be lethargic. On 11/04/05 blood cultures and urinalysis were sent. The physician was in to see the patient daily and documented on 11/05/05, the patient " having bed bath/shave and responding better today" .

The recorded temperature on 11/06/05 was 100.7. During the physician's visit with the patient on 11/06/05, it was documented "chest pain, worse with cough" and the patient was "worried about his current illness" . The patient continued to experience a febrile illness and blood sugar levels continued to rise. A laboratory blood test was performed on 11/06/05 at 10:34 a.m. and indicated a glucose level of 460. The physician was notified and at 11:20 a.m. orders were written. Intravenous fluids were changed to exclude dextrose, --- ---- and the patient was started on an insulin drip with hourly glucoscans. Due to the patient's report of chest pain and fevers the physician ordered on 11/06/05 a chest x-ray, electrocardiogram, laboratory tests --- ----; and to discontinue the PICC line and send the PICC line tip for culture. A cardiology consult was ordered on 11/06/05. The patient responded well to insulin therapy with glucose levels returning (90 ` s-120 ` s). It was documented the insulin drip was discontinued at 4:00 p.m. on 11/08/05. The patient was resumed on the sliding scale of Regular insulin and received Lantus 22 units subcutaneously twice a day until the patient was discharged on 12/08/05.

On 05/17/06, an interview was conducted with the Director of Clinical Services --- ----. H/She could not recall the patient being found by family in an unresponsive state before this incident or at any other time of this patient's hospitalization.

In summary, the allegation was unsubstantiated due to lack of evidence. There was no documentation in the medical record or per an interview with the Director of Clinical Services that the patient was found unresponsive.

Allegation: 7

Type: Resident/Patient/Client Rights

Findings: Unsubstantiated

Allegation Detail: The complainant alleges that the facility failed to keep the patient/family informed about/involved in the Plan of Care. The complainant alleges that the facility failed to communicate clearly to the patient/family about infection control concerns, dietary problems, rationale for transfer to LTC, discharge planning and the implications of the patient's declining condition.

Findings Detail: Please see previous responses to allegations regarding dietary rationale and infection control issues.

Briefly, upon review of the medical chart of the patient --- ----, a nutrition entry dated 10/24/05 revealed the patient "was not liking puree diet so changed to regular, but pt did not tolerate well per ST (speech therapy), pocketing foods ... wife feels pt's changes in diet may help with po (oral intake) ". On 10/28/05 it was recorded, " pt's wife had some issues at the beginning of this week but resolved regarding po (oral) diet; po diet clarified and downgraded to above diet --- ----. --- ---- The physician --- ---- documented "please reinforce --- ---- that all liquids, incl. soda, need to be thickened" . Throughout the patient's hospitalization, the patient had received speech therapy sessions regularly for dysphagia to assist him with swallowing problems. It was documented --- ----, "wife is actively involved" with patient's exercise process. Patient teaching was done, and the therapist documented --- ----.

On 11/09/05, a consult was performed by an infection control specialist --- ----. The physician documented --- ---- the pt's " wife declines TEE/Surgery " , and the patient was " more alert, but incoherent ". Another consulting physician --- ---- had documented on 11/10/05 a discussion with the " wife of the patient: not a surg (surgical) candidate, advised her that medical therapy alone has a high failure rate". This same physician on 11/12/05 had documented, " family aware of difficult prognosis" . On 11/11/05, the hospitalist --- ---- documented the patient "is on optimal abx (antibiotics) choices" --- - --- and the "pt's wife does not want surgery for him". The physician --- ---- documented in the progress notes, the patient "could go to a SNF (Skilled Nursing Facility) on current antibiotics".

A case management entry on the progress notes dated 10/25/05 indicated a bedside meeting which included the patient, patient's wife, case manager --- ---- and physician --- ----. There was concern expressed over the patient's lack of progress. The physician --- ---- explained the neurologist --- ---- "gives pt. poor prognosis for recovery" and the "pt ` s wife wants inpatient rehab eval (evaluation)" and "CM (case management) will contact --- ---- for an eval per her choice" .

On 10/26/05, CM documented "met with wife, explained pt may need SNF (skilled nursing facility) before rehab" . On 11/2/05, a case management note indicated --- ---- assessing today. On 11/18/05, the case manager met with the patient's daughter to explain --- ---- "could not accept pt because they do not have a private room for --- ----.

On 11/28/05, CM met with the "pt's wife to discuss the need for finding SNF placement in a facility that --- ----. The patient's wife was given names for SNF's in --- ---- to contact. On 12/7/05 CM documented " pt's wife has chosen --- ----.

An interdisciplinary team report dated 10/21/05 revealed a family conference "scheduled 10/25/05 with wife to report current status, d/c (discharge) planning, and prognosis" . Another interdisciplinary team report dated 10/27/05 indicated the "family educated on inpt (inpatient) rehab criteria and denials and is reviewing her SNF choices" . The interdisciplinary team report of 11/10/05 indicated "physicians and nurses inform wife regularly of medical status" . It was noted on 11/17/05, "met with wife and daughter to discuss the need to locate SNF with private room" . On 12/01/05 documentation stated "many conversations with pt's wife re: need to locate SNF. This week 12/06/05 she indicated she would consider 2 listed above" .

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In summary, the allegations were unsubstantiated. There were multiple documentations in the patient care record from various medical and health related disciplines that revealed the patient and his family were informed of the plan of care which included nutritional support, infection issues, current condition and prognosis, and appropriate long term care choices. On 12/08/05, the patient was discharged to the facility selected by the family.