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<tr>
<td>H 000</td>
<td>INITIAL COMMENTS</td>
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<td>An unannounced complaint survey for CCR# 2017006240 was conducted, on 06/23/2017 and 06/26/2017, at Palms West Hospital, License #4164, in Loxahatchee, Florida. The following is a description of the deficiencies, found at the time of the visit.</td>
<td>H 115</td>
<td>59A-3.2085(S), FAC NURSING SERVICE - Organized &amp; Staffed</td>
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<td>5. Each hospital shall be organized and staffed to provide quality nursing care to each patient. Where a hospital's organizational structure does not have a nursing department or service, it shall document the organizational steps it has taken to assure that oversight of the quality of nursing care provided to each patient is accomplished</td>
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<td>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure that oversight of the quality of nursing care provided to each patient is accomplished when removing a central venous catheter in 1 of 10 sample patients, Patient #5. The findings included:</td>
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<td>On 08/08/16, the clinical record revealed Patient #5 was admitted for a narcotic overdose, non-cardiogenic pulmonary edema, respiratory distress and Rhabdomyolysis. The patient was intubated in the emergency room and admitted to the Intensive Care Unit (ICU). On 08/15/16, the Critical Care Progress note revealed the patient was successfully liberated from the ventilator and was stable for transfer out of ICU.</td>
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On 08/19/16 at 10:35 AM, the clinical notes revealed the patient was able to ambulate and performed standing exercises by the edge of his bed with no loss of balance. The patient was alert, talking and eating.

On 08/19/16 at 1:15 PM, the nurses notes revealed the Left Intravascular Jugular (LIJ) catheter was removed without difficulty. The patient started to complain about burning in the middle of his chest with associated shortness of breath and diaphoresis. The patient's oxygen saturation (pulse oximeter reading) dropped to the 70's. The patient was placed back in bed.

On 08/18/16 at 2:20 PM, the critical care progress note by the physician revealed the patient suddenly became very agitated, hypoxic, and oxygen saturation dropped to 70% after removal of Central Venous Line from Left Intravascular Jugular per the Registered Nurse. The patient was intubated for respiratory failure. The note revealed: will get a chest x-ray stat - suspect air embolism / pulmonary embolism. The patient was placed on a ventilator.

On 08/21/16 at 2:06 PM, the hospitalist note revealed the prognosis is guarded; Patient is off sedatives, currently unresponsive, in deep coma from anoxic brain encephalopathy; No corneal reflexes; Highly likely brain death; the family declined any further tests, and requested to proceed with withdrawal of care in AM.

On 08/22/16, the Brief Death Summary Note revealed the patient passed away at 8:50 AM with title family members at the bedside.

Review of the Autopsy Report revealed the cause of death as complications of probable air...
embolism following removal of central venous catheter due to treatment of opiate overdose.

During an interview with Staff A, a registered nurse, on 06/26/17 at approximately 10:00 AM, she stated that she has been a registered nurse (RN) for 31 years. She stated that she has been working at this hospital since October 2014, in the Intensive Care Unit (ICU). She stated that Patient #5 was in the Intensive Care Unit (ICU) and she was assigned to care for the patient.

She stated the patient was sitting in the chair and a family member was in the room. She stated she took out the central venous catheter while the patient was sitting in the chair. She stated that removing the line while the patient was sitting in a chair is not the appropriate way. She stated the appropriate way is to have the patient lay down flat in the bed and hold their breath. She stated the patient, all of a sudden, grabbed his chest and said he was having a lot of pain. She stated that he was breathing and she and another nurse helped the patient stand and get into his bed. She stated the intensivist intubated the patient.

During an interview with the Director of the ICU, on 06/26/17 at approximately 9:45 AM, she stated that Staff A's action of removing the central venous line while the patient was sitting in a chair, was very surprising. She stated that when she was made aware of the autopsy report in January 2017, she spoke to Staff A and told her there was a possibility the patient expired due to the pulling of the central line while the patient was sitting up in a chair. She stated that Staff A admitted removing the line while the patient was sitting up in a chair. She stated the appropriate way and according to hospital policy is to have the patient in a Trendelenburg position, not sitting upright in a chair.
During an interview with the Chief Nursing Officer, on 06/26/17 at approximately 3:00 PM, she stated that she was informed about this case when the autopsy results came back in January. She stated that she does not remember who told her or who was involved in making the decision to not initiate an incident report when they found out about the autopsy report.

Review of the policy and procedure for the removal of Removal of Central Venous Catheters includes: 'place the patient in Trendelenburg position, if not contraindicated. Turn head to opposite side of central line.'

395.0197(1)(e) FS; 59A-10.0055(2)(a-b) RM Prog - Incident Reporting System

395.0197(1)(e) The development and implementation of an Incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed health care facility to report adverse incidents to the risk manager, or to his or her designee, within 3 business days after their occurrence.

59A-10.0055.

(2) INCIDENT REPORTS. The incident reporting system shall include the prompt, within 3 calendar days, reporting of incidents to the risk manager, or his designee. Reports shall be on a form developed by the facility for the purpose and shall contain at least the following information:

(a) The patient's name, location information, admission diagnosis, admission date, age and sex;

(b) A clear and concise description of the incident H115 Continued From page 3
H 410 Continued From page 4

including time, date, exact location; and elements as needed for the annual report based on ICD-9-CM:

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility's health care providers and employees failed to report an adverse incident to risk management within 3 business days after the occurrence of the intubation of a patient following the removal of a central venous line while the patient was sitting upright in a chair for 1 of 10 sample patients, Patient #5.

The findings included:

On 08/08/16, the record revealed Patient #5 was admitted to the Intensive Care Unit (ICU) for an opiate overdose. He was placed on a ventilator.

On 08/15/16, the record revealed the patient was removed from the ventilator and was to be moved out of the ICU. He was alert, talking and eating.

On 08/18/16, the record revealed Patient #5 developed acute dyspnea, diaphoresis and chest pain after his central catheter was removed while the patient was sitting upright. The patient became unresponsive, was intubated and placed on a ventilator. The patient never regained consciousness and his family members decided to withdraw life support. The patient passed away on 08/22/16, with his family members at the bedside.

During an interview with the Director of the Intensive Care Unit (ICU) on 06/26/17 at 9:45 AM, she stated that she did not file an incident report regarding the incident at the time of the event. She also stated that she did not discuss this incident with the "higher ups such as the Vice President of Quality", when she was told about the autopsy report in January 2017.

During an interview with the Director of Patient Safety and Risk Management on 06/26/17 at 2:00 PM, she stated the policy is to initiate an incident report when something happens outside of the normal, customary, routine happens. She stated the staff should have initiated an incident report when the patient had to be intubated following the removal of a central venous catheter while the patient was sitting in a chair. She stated this should have been reported as an adverse event, hospital acquired condition, code 15, serious event, and they should have completed a root cause analysis. She stated that had she been informed of this event at the time she would have filed a code 15. She stated that when the hospital received the autopsy report in January 2017, they looked at the nursing notes and knew what the root cause was. She stated they decided not to generate an incident report or report the incident.

Review of the nurses notes and critical care progress notes revealed they were aware of the incident and failed to initiate an incident report or report the adverse incident to the risk manager.

H 410 395.0197(5 &7) FS; 59A-10.002(5) FAC 15 DAY REPORTS

H 416
H 416 Continued From page 6

(5) For purposes of reporting to the agency pursuant to this section, the term "adverse incident" means an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and which:

(a) Results in one of the following injuries:
1. Death;
2. Brain or spinal damage;
3. Permanent disfigurement;
4. Fracture or dislocation of bones or joints;
5. A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility;
6. Any condition that required specialized medical attention or surgical intervention resulting from nonemergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent; or
7. Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient’s condition prior to the adverse incident;
(b) Was the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient’s diagnosis or medical condition;
(c) Required the surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process; or
(d) Was a procedure to remove unplanned foreign objects remaining from a surgical...
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<td>H416</td>
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<td>(7) Any of the following adverse incidents, whether occurring in the licensed facility or arising from healthcare prior to admission in the licensed facility, shall be reported by the facility to the agency within 15 calendar days after its occurrence: (a) The death of a patient; (b) Brain or spinal damage to a patient; (c) The performance of a surgical procedure on the wrong patient; (d) The performance of a wrong-site surgical procedure; (e) The performance of a wrong surgical procedure; (f) The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient’s diagnosis or medical condition; (g) The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process; or (h) The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure. The agency may grant extensions to this reporting requirement for more than 15 days upon justification submitted in writing by the facility administrator to the agency. The agency may require an additional, final report. These reports shall not be available to the public pursuant to s. 119.07(1) or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall they be available to...</td>
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the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.

59A-10.0065, F.A.C.
The facility shall report all incidences meeting the criteria specified in Section 395.0197(6), F.S., to the Agency within 15 calendar days of occurrence. The report shall be made on AHCA Form 3140-5001-August 1993, Code 15 Report which is incorporated by reference and may be obtained from the Agency for Health Care Administration. The agency may require an additional final report. Any reportable incidents pursuant to this section that are submitted more than 15 calendar days from occurrence by the facility must be justified in writing by the facility administrator.

59A-10.002
(5) "Injury" for the purposes of reporting to the Agency is any of the following outcomes when caused by an adverse incident:
(a) Death; or
(b) Brain damage; or
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(c) Spinal damage; or  
(d) Permanent disfigurement; or  
(e) Fracture or dislocation of bones or joints; or  
(f) Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition; or  
(g) Any condition requiring surgical intervention to correct or control; or  
(h) Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care; or  
(i) Any condition that extends the patient's length of stay; or  
(j) Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to report the death of a patient to the Agency for Health Care Administration within 15 calendar days after the patient was taken off the ventilator and pronounced dead for 1 of 10 sampled patients, Patient #5.

The findings included:

On 08/08/16, the clinical record revealed Patient #5 was admitted to the Intensive Care Unit (ICU) for an opiate overdose. The patient was placed on a ventilator.

On 08/15/16, the record revealed the patient was removed from the ventilator and was to be moved out of the ICU. The patient was alert, talking and eating.

On 08/18/16, the record revealed Patient #5
developed acute dyspnea, diaphoresis and chest pain after his central catheter was removed while he was sitting upright. The patient became unresponsive, was intubated and placed on a ventilator. The patient never regained consciousness and the family members decided to withdraw life support. The patient passed away on 08/22/16, with family members at the bedside.

Review of the hospital's 2016 Annual Report to AHCA failed to list a Code 15 for Patient #5's death. Review of grievance / complaint logs and the incident report logs for 2016, failed to reveal the incident that occurred with Patient #5 on 08/18/16.

During an interview with the Director of the Intensive Care Unit (ICU) on 06/26/17 at 9:45 AM, she stated that she did not file an incident report regarding the incident. She stated that she did not discuss this incident with the "higher ups such as the Vice President of Quality", when she was told about the autopsy report in January 2017.

During an interview with the Director of Patient Safety and Risk Management on 06/26/17 at 2:00 PM, she stated this should have been reported as an adverse event, hospital acquired condition, code 15, serious event, and they should have completed a root cause analysis. She stated that she had been informed of this event at the time she would have filed a code 15. She stated that when the hospital received the autopsy report in January 17, they decided not to generate an incident report or report the incident.