CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050168	A. BUILDING _____ B. WING _____	04/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Jude Medical Center	**101 E Valencia Mesa Dr, Fullerton, CA 92835-3809 ORANGE COUNTY**

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00225807, CA00222416 - Substantiated Representing the Department of Public Health: Surveyor ID # 22779, HFES The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.1(c): For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient. Health and Safety Code Section 1279.1(c): The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made. The CDPH verified that the facility had informed the patient or party responsible for the patient of the adverse event by the time the report was made. Deficiency Constituting Immediate Jeopardy T22 DIV5 ART3-70215 (a)(2). Planning and Implementing Patient Care. (a) A registered nurse shall directly provide: (2) The planning, supervision, implementation and			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Theresa Turley TITLE VP Clinical Excellence (X6) DATE 8-5-2013

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 8

HN 8/8/13

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. Except for nursing homes, the findings 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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	evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation. T22 DIV5 ART3-70213 (a). Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. The above regulations were NOT MET as evidenced by: Based on interview and record review, the hospital failed to ensure adequate nursing supervision and fall prevention measures were provided to Patient L per their policy and procedure (P&P), resulting in the patient's fall and subsequent death. Findings: On [redacted]10, the hospital notified the Department of a patient death possibly related to a fall (Patient L). On 4/12/10, the Department also received a complaint that Patient L had suffered an intracranial hemorrhage (bleeding within the skull) and died secondary to a fall on [redacted]10. According to the complainant, Patient L had urgency when toileting needs arose. According to the complainant, there were several episodes when a family member assisted the patient to the bathroom because		SJMC is committed to adhering to all relevant federal and State laws. This document is submitted as evidence of correction of the deficiencies identified during the April 2, 2010 survey. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by SJMC to the allegations or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by provisions of federal and State law. None of the actions taken by SJMC pursuant to its Plan of Correction should be considered an admission that a deficiency existed or that additional measures should have been in place at the time of the survey. SJMC submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil or criminal action or proceedings against SJMC, its employees, agents, officers, directors, or shareholders. This Plan of Correction is submitted to meet requirements established by State and federal law. **a) How the corrections will be accomplished, both temporarily and permanently.** Immediate changes in process made were:	5/2/10

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	nurses either did not come quickly enough or did not come and on one occasion the patient soiled himself. An additional concern expressed by the complainant was that the patient was given Ambien (zolpidem tartrate 5 mg, a sleeping pill) in the afternoon prior to the fall. The patient had no prior history of taking this medication at home and it made him confused. According to the complainant, the concerns regarding the delayed response to the nurse's call light coupled with the patient's urgency was expressed to the nurse caring for the patient on the evening of [redacted]10. The complainant only left the hospital after being assured by the nurse that the nurse would sit by the door and watch the patient. The hospital's P&P tilted Fall Risk Assessment and Intervention showed fall precaution strategies are to be initiated based on the assessment findings. For a patient with a fall risk score higher than 10 points, the following fall precautions are to be initiated: - Environmental identification that the patient is at risk for falls - Place an orange armband on the patient to identify as a fall risk - Place red slipper socks on the patient to further identify them to all nursing staff - Strongly consider "4 P's" rounds: potty (patient need for assistance to bathroom, bedside commode, or bedpan per physician order; placement of frequent use items close to the		Education was provided to nursing staff regarding the responsiveness to family members when an expressed concern for the patient's safety is conveyed, how to address their concerns and take action on the needs expressed. The process flow established will anticipate the need for the sitter or Patient Safety attendant (PSA). The number of patients that are assigned to one patient care tech (PCT) for sitter coverage was changed to restrict the patients to one room with up to 4 patients in a ward room, as appropriate. Communication between the RN and PCT for relieve coverage when attending to another patient needs was reinforced to include active hand-off communication with eyes on the patient. Escalation processes were updated to include the need for increased coverage when the patient may need 1:1 sitter. The reassessment of patients potential for fall risk already included the risk of sleep medication use, but was reinforced through education to staff of the potential risk. Instructions on the medication administration record were updated to include prompts regarding the potential effect on a patients fall risk status.	

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	patient; positioning in bed; and pain) - Observe the patient at frequent intervals if the patient is confused, has impaired gait, or is unable to bear weight. - Consider use of safety attendant - Communicate the patient's status and fall prevention measures on an ongoing basis in the nursing report. On 3/25/10, the medical record for Patient L was reviewed. The medical record showed Patient L was admitted to the hospital on [redacted]10. The initial nursing assessment dated [redacted]10 at 0342 hours, showed the patient was oriented to person, time, place, and situation. The physician's history and physical dated [redacted]10, showed the patient was [redacted] years old, alert, and oriented. A family member was present at the bedside during the physician's history and physical examination. There was no history of the patient using a sleeping medication. The plan of care for high risk of falls was initiated on [redacted] with the following approaches: monitor for fall risk factors, view risk for injury guidelines, physical assessment, pain assessment, vital signs, intake and output assessment, patient acuity, and patient care and treatment. The nursing assessment dated [redacted]10 at 0955 hours, showed the patient had a fall risk score of 9 (at moderate risk for falls). At 2000 hours, the documentation showed the patient was alert and		Nursing staff was provided "lessons learned" education from this event to include the need to reassess the patient, clear communication between the family members and the nursing staff. In addition the ultimate responsibility of the nursing staff in the prevention of falls, even when family members are present to provide assistance was included in the education. The utilization of hourly rounding and the attention to the patients elimination needs, is the expectation of staff every time they enter a patients room. The administration timeframe when a sleeping medication can be administered was presented to the Pharmacy and Therapeutics committee with a subsequent change in the timeframe when this classification of medication can be administered. Sleeping medication can be administered between 8 pm to midnight. Education to the staff on these interventions was completed. **b) The title or position of the person responsible for the correction.** Chief Nursing Officer Director of Medical/Surgical Nursing **c) A description of the monitoring process to prevent recurrence of the deficiency.** Monitoring performed: Sitter or PSA usage per nursing unit, use of restraints vs sitter use	

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	oriented. However, the patient's fall risk assessment score had increased to 15 points (at high risk for falls). The patient was uncooperative and the nursing intervention was "Family Sitter." Additionally, the nurse documented the patient's increased fall risk was addressed in the medical record with the nursing interventions including to identify the patient as a high risk for falls, communicate fall risk, and place a bed alert (a device placed under the patient that alarms when the patient attempts to get out of bed). Further review of the medical record showed no documented evidence the facility had reassessed, evaluated, planned, and implemented patient care safety interventions to ensure the patient was adequately supervised to prevent falls when the patient was identified to be uncooperative, have increased fall risk, and need a sitter (a person who would be staying with the patient at all times to watch the patient). There was no documented evidence the hospital had updated the patient's plan of care to address appropriate fall prevention measures or implemented fall precaution strategies as indicated in the P&P for Patient L who was identified to have a high fall risk score of 15 to prevent the patient from sustaining a fall. Medical record review showed the patient sustained a fall on [redacted]10 at 2130 hours. Although initially alert after the fall, the patient rapidly deteriorated and at 0210 hours, the patient was comatose and at 0620 hours, the patient was pronounced dead. A CAT scan (computer axial tomography, a		Observation audits by the nurse manager focused on fall risk patients when family members are involved in the care of the patient. The use of Ambien and the relationship to falls, with or without harm. This information will be incorporated into the QAPI plan. 2013 AUG 5 AM 11 22	

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medical imaging procedure utilizing computer-processed x-rays to produce tomographic images of specific areas of the body) of the head done on [redacted]10 at 2216 hours showed a high density hemorrhagic contusion (bleeding in the brain) over the right frontal lobe of the brain.

A repeat CAT scan done on [redacted]10 at 0400 hours showed a marked increase in the size of the hemorrhage with bleeding throughout most of the left side of the brain and a shift in the brain to the left.

On 3/25/10 at 0945 hours, RN (registered nurse) 1 was interviewed regarding events on the day of the patient's fall, [redacted]10. According to RN 1, the patient's family was with the patient throughout the day shift (0700-1900 hours). During the day shift, the family member was instructed to have staff help the patient to the bathroom. The RN stated the patient was fairly stable on his feet, but was given a walker to assist with ambulating. Additionally, the family member was concerned that the patient had not been sleeping well and requested a sleeping pill for the patient. The physician ordered zolpidem tartrate 5 mg to be given on [redacted]0 at 1401 hours, and it was given to the patient at 1539 hours on [redacted]10.

On 3/26/10 at 0846 hours, RN 2 was interviewed. According to the RN, when Patient L wanted to go to the bathroom he would not wait for assistance. The family was concerned about this and told the staff they would have to get to the room in a hurry.

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RN 2 stated at the beginning of the evening shift (1900-0700 hours) on [redacted]10, the patient's family member stated they were tired and were going home. According to RN 2, after the family left she sat outside the patient's door while charting to keep an eye on the patient. While she was watching the patient, the patient tried to get out of bed without assistance but the bed alarm was on and it went off and the RN was able to assist the patient. RN 2 stated she never saw the patient use the call light.

RN 2 stated she had to pass medications to her other patients, one of whom was on another hall. She stated she had asked CNA (certified nursing assistant) 3 to keep an eye on the patient while she was passing medications. RN 2 stated she was passing medications on the other hallway when she was notified Patient L had a fall. When she went into the patient's room, the patient was on the floor. The patient stated the bed was not like at home and wanted to go to the bathroom.

On 4/2/10 at 1622 hours, CNA 3 was interviewed. According to the CNA, on [redacted]10 at about 1830 hours, the family member was calling the front desk stating the patient needed to go to the bathroom right now. The CNA stated she had 11 patients and could not do something right away because she was with another patient. When she got to the room, another nurse was initially assisting the patient. CNA 3 then assisted the patient to the bathroom; however, the patient did not pull down his underwear but urinated on the underwear and the floor. After CNA 3 helped the patient back to bed, the family member told CNA 3 Patient L was

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	confused because of the medication. CNA 3 stated on another occasion during the evening of [redacted]10, the patient was observed pulling off the tape holding the IV (intravenous) tubing in place. Describing the events on [redacted]10, prior to the patient's fall, CNA 3 stated RN 2 had to pass medications, told CNA 3 the patient had a bed alarm on, and asked CNA 3 to keep an eye on the patient. While helping the patient in the next room, CNA 3 heard the bed alarm and a big noise. The patient was on the floor, and three siderails were up and one was down. The patient went to the bathroom after the fall. The patient showed impulsive behavior, did not use a call light, was using a walker for ambulation, had received a sedative-hypnotic, and had urgency when needing to use the rest room. There was no nursing supervision provided to the patient to ensure the patient was safe after the nursing staff had identified the patient had increased risk for falls and needed a sitter to prevent falls. This facility failed to prevent the deficiency(ies) as described above that caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1(c).			