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
	050115	A. BUILDING _____ B. WING _____	04/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palomar Medical Center	2185 Citracado Pkwy, Escondido, CA 92029-4159 SAN DIEGO COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00342790 - Substantiated Representing the Department of Public Health: Surveyor ID # 22363, HFEN 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. The following reflects the findings of the California Department of Public Health during the investigation of a complaint/self-reported event. Complaint Number: CA00342790 The investigation was limited to the specific complaint/self-reported event investigated and does not represent a full inspection of the facility. Representing the California Department of Public Health: Health Facilities Evaluator Nurse 22363 California Codes Health & Safety Code, Section 1279.1 (a)		This Page Intentionally Left Blank RECEIVED CA DEPT OF PUBLIC HEALTH MAY 21 2014 LICENSING & CERTIFICATION SAN DIEGO NORTH DISTRICT OFFICE	

Event ID.L6DU11 4/2/2014 8:10:22AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Jay Herzer TITLE Chief Nursing Officer (X6) DATE 5-16-14

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s) 1 thru 7

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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	(a) A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law. California Codes Health & Safety Code, Section 1279.1 (b)(5)(D) (b) For purposes of this section, "adverse event" includes any of the following: (5) Environmental events, including the following: (D) A patient death associated with a fall while being cared for in a health facility. California Codes Health & Safety Code, Section 1279.1 (c) (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 informed the patient or the party responsible for the patient of the adverse event by the time the report was made. California Codes Health & Safety Code Section 1280.1 (c) (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.		This Page Intentionally Left Blank RECEIVED CA DEPT OF PUBLIC HEALTH MAY 21 2014 LICENSING & CERTIFICATION SAN DIEGO NORTH DISTRICT OFFICE	

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	California Code of Regulations, Title 22, Chapter 1, Sections 70213 (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. 70215 Planning and Implementing Patient Care (b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission. The facility failed to implement existing written policy regarding using the prescribed nursing intervention and plan of care for fall prevention. As a result, Patient 1 fell and sustained a skull fracture with bleeding in the brain, and coma. Ultimately, life support was withdrawn and Patient 1 expired in the hospital two days after falling. Findings: Per the history and physical dated [redacted]3, Patient 1 a 68 year old male, was admitted on [redacted]3 to the facility for respiratory failure, pneumonia, and stomach cancer. Notations in the electronic medical record (EMR) indicated Patient 1 was transferred from the Intensive Care Unit (ICU) to the Intermediate Care		This Page Intentionally Left Blank	

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	Unit (IMC) on 2/5/13. The nursing staff completed ongoing assessments for the risk of falls and determined Patient 1 was at risk for falls. Patient 1 was assigned a point total of 70 on the day of admission [redacted]/13. The point value system equated the higher the point value with increased risk for fall. The range in point value for Patient 1 was 70 on admission to 35 on [redacted]/13. Prior to the fall event on [redacted]/13, Patient 1 was assessed by the professional nursing staff for fall risk and was assigned a point value 45 on [redacted]/13 at 8 AM; 50 on [redacted]/13 at 7:45 PM. The plan of care per hospital policy was to include the use of a bed alarm. The use of the bed exit alarm was one of the primary nursing interventions, and was outlined hospital's policy and procedure titled, "Fall Prevention and Management," section 4.C., and was to be implemented with a fall risk point value of 45. The facility utilized a call/bed exit alarm system that rings directly to hand held phones carried by Certified Nursing Assistant (CNA) and licensed nursing staff. If a patient attempted to exit out of bed the initial alarm goes to the CNA and the RN. If there is no response after one minute, then the system alerts "all" staff on the specific nursing unit. Administrative staff stated the alarm must be canceled from within the patient's room. The call bell/bed exit alarm tracking record for the morning of [redacted]/13 was reviewed with administrative staff on 4/24/13. According to the tracking record, the alarm failed to go off the morning of [redacted]/13 when		This Page Intentionally Left Blank	

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	Patient 1 was found on the floor at 8:15 AM. Administrative staff acknowledged the alarm had been turned off. CNA 1 was interviewed on 3/29/13 at 8:00 AM, and confirmed caring for Patient 1 on the evening of [redacted]13 to the morning of [redacted]/13. According to CNA 1, Patient 1 was confused, agitated and attempted to get out of bed after midnight on [redacted]/13. CNA 1 recalled having to remind Patient 1 to stay in bed several times. LN 5 was interviewed on 3/28/13 at 10:00 AM, and confirmed she was caring for Patient 1 on the morning of [redacted]13, and recalled the incident very clearly. According to LN 5, night shift nurse (LN 6) had reported to her that Patient 1 had been extremely anxious and confused since midnight requiring constant observation. LN 5 stated LN 6 told her that CNA (CNA 1) and LN 6 were running in and out of Patient 1's room all night due to constant attempts to get out of bed. LN 5 recalled that on the morning of [redacted]13, she had received a phone call from the cardiac monitoring staff indicating Patient 1 was possibly detached from the cardiac monitor. LN 5 went to the room of Patient 1, and found him on the floor at 8:15 AM. The bed alarm system was not activated. The nursing note documentation related to the event on [redacted]13, indicated the LN 5 responded to a notification from the cardiac monitoring station that		This Page Intentionally Left Blank	

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	Patient 1's cardiac rhythm had been interrupted. Upon arriving at Patient 1's room "3- 4 people were already in patient's room helping patient to get from floor." The EMR notes from LN 5 following report from LN 6 were also reviewed with administrative staff. According to LN 5's documentation on [redacted]13 timed 7 AM, "During report learned that patient has been confused and combative since midnight and almast (almost) continues (continuous) care from night RN as well as night CNA was required in order to keep patient safe and in bed. Pt. (patient) was trying to climb out of bed, and was unstable on feet. Informed that sitter for the patient is unavailable and bed alarm is on." LN 6, the nurse caring for Patient 1 on the evening of [redacted]/13 to the morning of [redacted]13 was interviewed on 3/26/13 at 8:20 AM, and stated Patient 1 was "confused" and had made several "attempts to get out of bed" throughout the night, despite being directed to stay in bed. LN 6 recalled medicating Patient 1 at 12:45 AM with Xanax (an antianxiety medication) "so he'd go to sleep." On [redacted]13 at 7:48 PM, LN 6 assessed Patient 1 to be alert, oriented to person, place, time, and following commands at the beginning of her shift and assigned a point value of 50 for fall risk. On [redacted]13 at 0100, LN 6 documented Patient 1 had become "confused /disoriented and forgetful". Patient 1 was found on the floor of his room at 8:15		This Page Intentionally Left Blank	

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	AM on [redacted]13, and the bed alarm system was not activated. Patient 1 was evaluated by Physician M post fall on [redacted]13 and documented the following: slip and fall, large left side brain bleed, skull fractures which consisted of both displaced and non-displaced. Physician M documented on the [redacted]13 evaluation he had consulted with the family of Patient 1, and a decision was made not to intervene surgically. Patient 1 was made a "no code" (no resuscitative measures or interventions) and comfort care was to be provided. Patient 1 expired in the hospital on [redacted]13. The facility's failure to implement existing written hospital policy related to the use of prescribed nursing intervention and implementing the plan of care for fall prevention resulted in Patient 1 falling and sustaining the traumatic head injury. This is a deficiency that has caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of the Health and Safety Code Section 1280.1 (c). 3		Requirements for the plan of care revieweed and the procedure was changed to only allow RNs to turn the bed alarms off Education was provided to all staff on use of "silence alarm feature of the bed. Monitoring Competency completion forms Person Responsible Director of Progressive and Acute Care Daily round are done to ensure that bed alarms are activated on patients at risk for falls Monitoring Daily logs completed ongoing Person Responsible Director of Progressive and Acute Care	Feb. 28, 2013 and ongoing.