

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/13/2013
NAME OF PROVIDER OR SUPPLIER University of California, San Diego Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 W Arbor Dr, San Diego, CA 92103-1911 SAN DIEGO COUNTY		
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	<p>The following reflects the findings of the Department of Public Health during an inspection visit:</p> <p>Complaint Intake Number: CA00357013 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 22479, HFEN</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>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.</p> <p>The following reflects the findings of the California Department of Public Health during the investigation of Entity Reported Incidents : CA00356618 and CA00357013</p> <p>Representing the Department: 1914</p> <p>1280.1 (a) Health and Safety Code Section 1280 (a) If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed</p>	<p>APR 10 2014</p>	<p>Plan Of Correction: The Panic Button on 8 East, where patient 1 was located, was repaired on 5/28/13.</p> <p>Patients on the other inpatient units may be affected by a non-functioning Panic Button. In order to ensure Panic Buttons on the other inpatient units are functional, all the Lynx Panic System buttons located in the inpatient units at the Cardiovascular Center, Thornton Hospital and Hillcrest Medical Center were checked and repaired as necessary and have been verified as functional as of 6/14/13 at 1830.</p> <p>The remainder of the Lynx Panic System buttons in clinical areas were checked and repaired as needed to ensure operational by end of next operational day.</p> <p>All Lynx Panic System buttons in- patient care areas were upgraded to a version that allows real-time notification to security if the panic button loses communication / connectivity. Security immediately follows up with the patient care area to regain connectivity by instructing them to reboot the computer. If this action does not work, further attempts to repair the button will be made within 24 hours and a sticker is placed on the button showing it to be out of service and to contact security as per policy via x6111.</p>	<p>Repaired 5/28/13</p> <p>Completed 6/14/13</p> <p>Completed by 6/17/13</p> <p>Completed by 9/30/13</p>

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3/28/2014

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 10

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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	<p>twenty-five thousand dollars (25,000) per violation.</p> <p>(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 a patient.</p> <p>(d) This section shall apply only to incidents occurring on or after January 1, 2007. With respect to incidents occurring on or after January 1, 2009, the amount of the administrative penalties assessed under subdivision (a) shall be up to one hundred thousand dollars (\$100,000) per violation. With respect to incidents occurring on or after January 1, 2009, the amount of the administrative penalties assessed under subdivision (a) shall be up to fifty thousand dollars (\$50,000) for the first administrative penalty, up to seventy-five thousand dollars (\$75,000) for the second subsequent administrative penalty, and up to one hundred thousand dollars (\$100,000) for the third and every subsequent violation. An administrative penalty issued after three years from the date of the last issued immediate jeopardy violation shall be considered a first administrative penalty so long as the facility has not received additional immediate jeopardy violations and is found by the department to be in substantial compliance with all state and federal licensing laws and regulations. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section.</p> <p>1279.1. (a) A health facility licensed pursuant to</p>		<p>Medical Center Policy 538.2, "Security Management Program" was revised to define the process for contacting security for emergent and non-emergent issues, specific to simultaneously pushing the panic button and calling security for emergent issues. (See Attachment C1) The policy was approved by the Environment of Care Committee (EOCC) and Senior Management Team (SMT).</p> <p>Staff in clinical care areas that have Lynx Panic System buttons were educated via email with attestation or sign-in sheet on how to contact Security for emergent situations, to include pushing the button and simultaneously calling Security. (See Attachment C2)</p> <p>A risk assessment was performed to assess the area-specific need for the Lynx Panic System to notify Security in emergent situations. (See Attachment C3)</p> <p>Responsible person(s) : Director of Security Associate Administrator, Hospitality and Safety Services Interim Chief Operating Officer / Chief Nursing Officer (current title, Chief Clinical Officer)</p>	<p>Approved by EOCC 6/20/13 SMT 6/20/13</p> <p>Education Completed by 6/19/13</p> <p>Assessment completed by 6/19/13</p>

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	<p>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.</p> <p>(b) For purposes of this section, "adverse event" includes any of the following:</p> <p>(3) Patient protection events including the following:</p> <p>(B) Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision making capacity.</p> <p>Title 22 Regulation 70837 (a)</p> <p>The hospital shall be clean, sanitary and in good repair at all times. Maintenance shall include provision and surveillance of services and procedures for the safety and well-being of patients, personnel and visitors.</p> <p>The above regulation was not met as evidenced by:</p> <p>Based on observations, interview, and record review, the hospital failed to ensure that all parts of the security notification process were working</p>		<p>Monitoring: All of the Lynx Panic System buttons will be checked for appropriate functioning on a monthly basis. Any identified non-functioning buttons will be fixed within 24 hours. For buttons that cannot be repaired within 24 hours, a sticker will be placed on the button until repaired showing it to be out of service and to contact security as per policy via x6111.</p> <p>Documentation of the monthly Lynx Panic System button checks and actions taken as necessary to ensure functional, will be performed on the "UC San Diego Medical Center Monthly Panic Button Testing Log".</p> <p>Results of the monthly testing will be reported to the Director of Security on a monthly basis. Further actions will be taken as necessary.</p> <p>Additionally, results will be reported to the Environment of Care Committee on a quarterly basis. Further actions will be taken as necessary</p> <p>Responsible person(s): Director of Security</p>	<p>Began 6/14/13 ongoing</p> <p>Began 6/20/13 ongoing</p> <p>Began 7/15/13 ongoing</p> <p>Begin 9/16/13 ongoing</p>

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	<p>properly when Patient 1 eloped from the hospital which caused a delay in the response of security agents to the nursing unit. In addition, the hospital had no written process or procedure regarding how staff was to contact security in the events of an emergency. Further, the hospital had no process in place for staff or security to identify patients who should not be independently ambulating around the hospital or leaving the building because of safety reasons. The hospital also failed to ensure that a panic button located on the 8th floor in a nursing station, which staff relied on for a prompt security response, was repaired in a timely manner. As a result, Patient 1 eloped from the hospital and was found expired in the canyon next to the hospital's parking structure four days later.</p> <p>Findings:</p> <p>A review of Patient 1's medical record was conducted on 6/14/13 which showed that Patient 1 was admitted to the hospital on [REDACTED] 13, for injuries sustained after falling down ten (10) steps prior to his arrival at the hospital. Patient 1 sustained a subarachnoid hemorrhage (bleeding between the brain and the thin tissue that covers it), scalp laceration, and a fracture of the first and second cervical vertebrae (neck bones).</p> <p>It was documented in Patient 1's most recent nursing assessment, dated [REDACTED] 13 at 8:00 pm, that prior to his elopement, Patient 1 was:</p> <p>Oriented to situation; Oriented to person; Disoriented to place; Disoriented to time.</p>		<p>Plan of correction: A process was implemented to identify patients that have the ability to leave their inpatient unit on their own, (i.e. via ambulation or wheelchair) AND it may be unsafe for them to leave the unit while unaccompanied by a staff member or adult family member. This process includes the application of a uniquely colored and identifiable orange armband. This is to identify these patients in the event they leave the inpatient nursing unit or the hospital unaccompanied by either a staff member or adult family member.</p> <p>Medical Center Policy (MCP) 303.5, "Patient Leaving Against Medical Advice (AMA) & Patient Elopement" was revised to include this new process. The MCP was approved by the Nurse Executive Committee (NEC) and Medical Staff Executive Committee (MSEC) (See Attachment D1)</p> <p>Nursing staff, including nursing staff on the unit where the patient eloped from, were educated on the process to identify these patients and appropriate actions to take. This education was provided via email with attestation or sign-in sheet. (See Attachment D2)</p>	<p>Completed 6/14/13</p> <p>Approved by NEC 6/19/13 and by MSEC 6/20/13</p> <p>Educa- tion Com- pleted 6/19/13</p>

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	<p>A Nursing Care Plan was developed at the time of Patient 1's admission due to the fact that he was assessed to be a high fall risk. At the time of his elopement Patient 1 had a bed alarm and was being monitored by a portable video camera in the room that was monitored in a centralized location by a Video Monitoring Technician.</p> <p>An interview was conducted, on 6/12/13 at 7:30 A.M., with the Clinical Care Partner (CCP 1) assigned to Patient 1 on [REDACTED] 13. CCP 1 stated that early in the morning of [REDACTED] 13 she had gone to the hospital's laboratory (lab). When she returned from the lab the telephone was ringing in the nurses' station. CCP 1 answered the phone and was informed by the Video Monitoring Technician that Patient 1 was getting out of bed. CCP 1 went to Patient 1's room but Patient 1 was not in the room. CCP 1 informed Patient 1's Registered Nurse (RN 1) that Patient 1 was missing. RN 1 informed the Charge Nurse, who paged security by calling their pager number twice and pushing the panic button twice, while RN 1 and CCP 1 went looking for the patient. CCP 1 further explained that she checked the nursing unit for Patient 1 and then went in the elevator down to the first floor and the basement in search of Patient 1. When she returned, security was not on the nursing unit so she called security, via the telephone, dialing the extension number for security. When she reached security, CCP 1 told them the Charge Nurse had paged security with no response and then hit the panic button still with no response from security. During the interview CCP 1 stated "It took too long</p>		<p>All staff were educated on the meaning and purpose of the orange armband and what actions to take if the patient is found unattended off of their inpatient unit. This education was provided via email with attestation or sign-in sheet. (See Attachment D3)</p> <p>Responsible person(s) : Interim Chief Operating Officer / Chief Nursing Officer (current title, Chief Clinical Officer)</p> <p>Monitoring: Once a week for 4 weeks and once a month for 2 months each inpatient nurse manager will review 100% of patients on unit of responsibility for compliance with the revisions to MCP 303.5. Further actions will be taken as necessary.</p> <p>Aggregate and unit specific results will be reported to the Nurse Executive Committee (NEC) on a monthly basis for 3 months. Further actions will be taken as necessary</p> <p>Responsible person(s) : Director of Nursing Quality Interim Chief Operating Officer / Chief Nursing Officer (current title, Chief Clinical Officer)</p>	<p>Educa- tion Com- pleted 6/19/13</p> <p>Auditing began 6/24/13 to 9/24/13 Ongoing if com- pliance not met</p> <p>Report- ing monthly 7/26/13 to 9/27/13 Ongoing if com- pliance not met</p>

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	<p>for a Security Agent to come to the floor. It took about ten minutes."</p> <p>On 6/12/13 at 1:15 P.M., an interview was conducted with Patient 1's attending physician (MD 1). MD 1 stated that although Patient 1 was able to perform his own activities of daily living, he had no capacity to sign consents and would not have been permitted to leave the hospital Against Medical Advice (AMA - a term used when a patient checks himself out of the hospital against the advice of their doctor). MD 1 further explained that Patient 1's level of confusion would "wax and wane" (alternate).</p> <p>An interview was conducted with the nursing unit's Charge Nurse (Charge RN 1) on 6/12/13 at 4:00 P.M. Charge RN 1 stated that after RN 1 informed her that Patient 1 was missing she paged security by calling their pager twice with no response. Then, Charge RN 1 stated that she pushed the panic button under the unit secretary's desk twice with no response from security. Charge RN 1 further stated that security did not respond within an appropriate amount of time, in her opinion.</p> <p>An interview was conducted with the Director of Security (DS) on 6/11/13 at 1:30 P.M. The DS acknowledged that the panic button was not functioning when Charge RN 1 pushed it twice in order to contact security. Once activated, the panic button should transmit to each Security Agent's radio with an audio message to inform the Security Agent the location where the panic button was pushed. At the same time the Dispatcher</p>				

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	<p>would call the nursing unit to find out why the panic button was pushed and the appropriate number of Security Agents would be sent to the nursing unit.</p> <p>On 6/14/13 at 9:40 A.M., a second interview was conducted with the Director of Security (DS). The DS stated that on [REDACTED] 13 at about 5:50 A.M. the Video Monitoring Technician called the nursing station to inform them that Patient 1 was getting out of bed. When his CCP got to Patient 1's room, he was gone. The DS further stated that security was paged on two occasions, about one minute apart, but security never received those two pages. The DS stated that he was concerned that the pages were never received by security. The DS said that the security pagers should not be used to contact security in an emergency. The Security Department prefers a phone call not a page to notify security of an emergency. He explained that the staff should push the panic button and dial 6111. The DS further explained that after the nursing unit got no response from using the pager to contact security, Charge RN 1 pushed the panic button but the panic button did not work. Once activated, the panic button should transmit to each Security Agent's radio with an audio message to inform the Security Agent the location where the panic button was pushed. At the same time the Dispatcher would call the nursing unit to find out why the panic button was pushed and the appropriate number of Security Agents would be sent to the nursing unit. The DS acknowledged that parts of the security notification process were not working causing a delay in the response of security agents to the nursing unit when a patient</p>			

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	<p>eloped. More importantly, the DS acknowledged that the hospital had no written process or procedure regarding how staff was to contact security in an emergency.</p> <p>The DS further stated that on 5/20/13 a security technician was aware of the inoperable panic button in the nursing station on 8 East. The DS stated that the security technician had other assignments from 5/20/13 through 5/24/13. The DS explained that 5/25/13 and 5/26/13 was a weekend and 5/27/13 was a holiday. The panic button in the nursing unit on 8 East was repaired on 5/28/13. Patient 1 eloped from 8 East on [REDACTED] 13. During the interview with the DS on 6/14/13, the DS stated that it was "not optimal to wait eight days to repair the panic button on 8 East." The DS stated that he would have preferred to see the panic button repaired the next day (5/21/13). Finally, the DS acknowledged that, at the time of Patient 1's elopement, the hospital had no process in place for staff or security to identify a patient who should not be independently ambulating around the hospital or leaving the building because of safety reasons.</p> <p>On 6/12/13 at 9:50 A.M., four surveyors went to the nursing unit where Patient 1 eloped from, escorted by the Director of Security (DS) and the Director of Regulatory Affairs (DRA). The surveyors and escorts retraced the route that Patient 1 took after leaving his room on the 8th floor at approximately 5:50 A.M. on [REDACTED] 13, when he is believed to have exited the building. Patient 1 walked out of his room in a patient gown and non-skid socks. He had a cervical collar in place and walked past two</p>			

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	<p>sets of elevators and down a corridor that connects to the main tower of the hospital and took the elevator down to the front lobby of the hospital. It was confirmed by video surveillance cameras that Patient 1 exited the hospital via the front doors and turned right. He was last seen on the video camera across the street from the hospital and across from the hospital's parking structure that borders on a very wide and deep canyon. It was explained to the surveyors that it was not suspicious to see patients leaving the hospital in a hospital gown especially since the hospital became a no-smoking campus. Patients have often left the hospital in patient gowns to go to an area outside of the hospital where smoking is acceptable.</p> <p>On 6/12/13 at 1:15 P.M. an interview was conducted with Patient 1's attending physician (MD 1). MD 1 stated that although Patient 1 was able to perform his own activities of daily living, he had no capacity to sign consents and would not have been permitted to leave the hospital Against Medical Advice (AMA - a term used when a patient who checks him or herself out of the hospital against the advice of their doctor). MD 1 further explained that Patient 1's level of confusion would "wax and wane" (alternate).</p> <p>On [REDACTED] 13, Patient 1 was noted to be moderately independent with ambulation with a front wheel walker (FWW). On [REDACTED] 13, Patient 1 was noted to have an unsteady gait. At the time of his elopement, Patient 1 remained a fall risk.</p> <p>On [REDACTED] /13, Patient 1 was found expired at the</p>			

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	<p>bottom of the canyon located next to the hospital's parking structure. Patient 1's final autopsy report was reviewed on 9/26/13. The autopsy results were listed as:</p> <p>Cause of Death: Acute Bronchopneumonia (inflammation of the walls of the smaller bronchial tubes of the lung) and Dehydration</p> <p>Due to: Environmental Confinement in Canyon</p> <p>Contributing:</p> <p>Hepatic Cirrhosis (a chronic degenerative disease of the liver) Coronary Artery Atherosclerosis (narrowing of the arteries of the heart) Recent Cervical Spine Fracture (spinal bone in the neck)</p> <p>Manner of Death: Accident</p> <p>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).</p>			

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