

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  060289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/29/2012
NAME OF PROVIDER OR SUPPLIER  Seton Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Sullivan Ave, Daly City, CA 94015-2200 SAN MATEO 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: CA00320085 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 25732, 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>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."</p> <p>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.</p> <p>T22 DIV5 CH1 ART3-70213(b) Nursing Service Policies and Procedures.</p>		<p>MAR 27 2015</p> <p>LECTURER</p> <p>SAN FRANCISCO</p> <p>POC accepted</p> <p>AJM 3-27-15</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Julia Magdal RN* TITLE *Quality Coordinator* (X6) DATE *3-27-2015*

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 17.  
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 60 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>(b) Policies and procedures shall be based on current standards of nursing practice and shall be consistent with the nursing process which includes: assessment, nursing diagnosis, planning, intervention, evaluation, and, as circumstances require, patient advocacy.</p> <p>This RULE: is not met as evidenced by:</p> <p>Based on interview and record review the hospital failed to ensure, that nursing staff, as a standard of practice, implemented a comprehensive Post Fall Assessment (PFA) when Patient A fell in the shower room. There was no policy and procedure in place requiring nursing staff to do a Post Fall Assessment. After Patient A fell and hit her head, the hospital failed to ensure that the following components of a Post Fall Assessment were done: an emergent CT Scan [computed tomography (CT) scan uses many x-rays to create pictures of the head to check for brain injury or bleeding], adjustment or stoppage of anticoagulant(blood thinners) therapy and frequent neurological checks(bedside exam of level of consciousness, eye reactions to light and reflexes that help determine severity of brain injury) at the bedside.</p> <p>This deficient practice resulted in a situation that has caused, or is likely to cause serious injury or death to Patient A, due to hemorrhage (bleeding) and brain damage from a fall.</p> <p>Findings:</p>		<p>The Fall Documentation assessment was integrated into our electronic medical record (EMR) in June 2012. It is a comprehensive Post Fall Assessment (PFA) designed to document the circumstances of a patient fall and post-fall interventions.</p>	October 2012

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	<p>During an interview on 9/20/12 at 2:30 PM, the hospital's Risk Manager (RM-1) provided a summary of the reported Adverse Event: Fall resulting in death. RM-1 said, "Patient A, who was [REDACTED] was admitted from the Emergency Department to the telemetry unit on 7/22/12 with diagnoses including shortness of breath, congestive heart failure and hypertension. Patient A was alert and followed commands. Patient A had a right lower arm cast from a previous fall at home and could ambulate with a walker. Patient A was rated as High Risk for a fall in the hospital. On the evening of 7/24/12 the patient was found on the floor in the shower. She had a small bump on her head. No other changes in her condition were observed at that time. On the afternoon of 7/25/12 a change in Patient A's gait was noted by the Physical Therapist. Shortly thereafter there was an acute change in her mental status and physical condition. Despite medical intervention, her condition continued to decline. On 7/27/12 Patient A was declared brain dead. Patient A subsequently expired on 7/27/12."</p> <p>In the same interview RM-1 was asked if there was a hospital procedure, policy or form that indicated what nursing should do after a patient falls. RM-1 said "No, the nurses just record the vital signs and neuro checks in their notes. We are working on something like that."</p> <p>In the same interview the Nursing Supervisor</p>		<p>Nursing education pertaining to falls was provided at the 6<sup>th</sup> floor's October 2012 staff meeting. The nurses were instructed that the <i>Fall Documentation</i> PFA and post-fall interventions shall be completed immediately after a patient fall. The <i>Fall Risk Reassessment</i>, done every shift to assess the patient's risk of fall, shall be completed after the fall, and the Plan of Care shall be updated to incorporate post-fall interventions.</p>	October 2012

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	<p>(NS-1), who was responsible for managing the telemetry unit that Patient A was in, was asked if there was a policy and procedure in the hospital that told what nurses were to do after a fall occurred. NS-1 said, "No, there was not."</p> <p>Review of Evidence-Based Geriatric Nursing: Protocols for Best Practice, 4th Edition, New York: Springer Publishing Company; 2011, Page 291, recognized as a national professional standard of care, indicates "...Nursing Standard of Practice Nursing Care Strategies... 4. Provide staff with clear written procedures describing what to do when a patient fall occurs."</p> <p>The Post Fall Assessment(PFA) is a procedure that describes what to do after a patient falls. There was no written PFA procedure in place when Patient A fell.</p> <p>Review of Evidence-Based Geriatric Nursing: Protocols for Best Practice, 4th Edition, New York: Springer Publishing Company; 2011, Page 278 indicates, "The PFA is a comprehensive, yet fall focused history and physical examination of the present problem(falling),coupled with a functional assessment, review of past medical problems, and medications. Clinical fall prevention guidelines are very clear about all the necessary components for inclusion for patients who have fallen which include fall history; fall circumstance; medical problems; medication review; mobility assessment; vision assessment; neurological examination,</p>		<p>The Long Term Care policy <i>Falls, Assessment of Resident</i> was used to develop the acute care policy entitled <i>Falls, Assessment of Patient Post-Fall</i> (see attachment A). The policy outlines the immediate interventions to implement: assessment of fall history; fall circumstance; medical problems; neurologic and cardiovascular assessments; medication review, including anticoagulant/antiplatelet therapy, notification of the MD, nursing supervisor, and nurse manager, recommendations for holding anticoagulant/antiplatelet therapy and for CT scan if head trauma suspected or head struck during fall; notification of family; and documentation.</p>	3/17/2015

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	<p>Including mental status and cardiovascular assessment."</p> <p>Review of a model Post Fall Assessment Protocol found in the Journal Nursing Care Quality (Vol.25, No 4, pp. 358-366 Copyright 2010) Indicates nursing staff should have taken these following steps after the Patient A's fall:</p> <p>Assessment</p> <ul style="list-style-type: none"> <li>-review patient medications, anticoagulant/antiplatelet therapy</li> <li>-Inform physician of patient medications including use of antiplatelet (i.e. Clopidogrel [Plavix] and aspirin)</li> </ul> <p>When requesting patient evaluation by the physician:</p> <ol style="list-style-type: none"> <li>a. recommend CT Scan for head injury,</li> <li>b. request orders to hold anti-platelets and anticoagulants as appropriate.</li> </ol> <p>Record review of a Medication Administration Record for Patient A, on 7/25/12 indicates she was taking Aspirin 81 milligrams and Clopidogrel [Plavix]75 milligrams once a day. These two medications are antiplatelets. (a group of medicines that stop blood cells (called platelets) from sticking together and forming a blood clot i.e. blood thinners)</p> <p>Record review of Patient A's Patient Care Nursing Note written by Registered Nurse 1(RN-1) on 7/24/12 indicated: "4 PM...Start of shift...received patient from day nurse, patient</p>		<p>The policy <i>Falls, Assessment of Patient Post-Fall</i> includes review of patient medications, including anticoagulant/antiplatelet therapy. It states that the physician is to be informed of anticoagulant/antiplatelet therapy therapy, and when requesting physician evaluation of the patient, that head CT scan be recommended for suspected head injury and that request to hold anticoagulant/antiplatelet therapy be made.</p>	3/17/2015	

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	<p>resting comfortably in bed...denies any pain or discomfort. Call light is within easy reach...will continue to monitor...11 p.m....Fall...CNA (Certified Nursing Assistant) found patient on shower floor. Patient denies pain...reports wanting to take a shower...two person assist to chair...ice pack applied to head. Reminded patient not to get up without assistance...notified charge nurse, paged medical doctor x 2 still awaiting call back...Physician paged at 1:20 AM concerning patient fall...Physician informed... no actions ordered will continue to monitor..." The note did not address a request for an order holding antiplatelet medication or recommending a head CT scan as indicated in the PFA Protocol listed above. The note did not indicate that a neurological examination was conducted by the nurse as mandated by the PFA. Part of a neurological exam entails examining the pupils of the eyes and evaluating a patient's grip strength. Changes in eye pupils reaction to light and grip strength may indicate early signs of brain injury caused by a fall with head trauma.</p> <p>Review of "Predicting Intracranial Traumatic Findings on Computed Tomography in Patients with Minor Head Injury: The CHIP Prediction Rule", (Annals of Internal Medicine 2007; Vol. 146: pages 397-406) indicated; CT scan is indicated, to rule out intracranial bleeding, when a patient experiences minor head injury with the following factors; a fall from any height and age over 60.</p>		<p>The Fall Committee met on 3/24/2015 and revised the <i>Fall Documentation</i> assessment to reflect all elements of the <i>Fall, Assessment of Patient Post-Fall</i> policy. It will be incorporated into the EMR in April 2015.</p> <p>Education pertaining to the <i>Fall, Assessment of Patient Post-Fall</i> policy and the <i>Fall Assessment</i> revisions will be provided to all acute care nurses, including those involved in the incident. Nurses unable to attend the in-services will be provided the information upon their return to work.</p>	<p>3/24/2015</p> <p>4/15/2015</p>

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	<p>Patient A was over 80 years of age and had experienced a head injury.</p> <p>In interview on 10/4/12 at 4 PM, RN-1 was asked what happened when Patient A fell. RN-1 said "I came on shift at 3:30 PM. Patient A was alert and oriented to time, person and place. She had just had her Foley catheter (urinary drainage tube) removed. She could get up herself. She was cooperative. At 11 PM the CNA went to check on Patient A because the front desk had told her that her heart monitor lead had slipped off. The CNA found Patient A on the floor of the shower room gripping the curtain. The CNA called me over. Patient A told me she tried to get up to take a shower. I did a mini-mental exam (bed side test to determine mental impairment) and palpated a bump on her head. There was no open area or laceration. We helped her to a chair. I applied ice to the back of her head. I attempted to call the hospitalist (In hospital Physician) two times. I was told by the charge nurse that the hospitalist physician was off and to call the Resident on-call physician. I described the situation on the phone to the Resident Physician. There were no new orders and the Resident Physician did not come to see the patient." RN-1 did not state that she had told the Physician that Patient A was taking blood thinners and that a CT head scan may need to be ordered.</p> <p>In the same interview RN-1 was then asked if she had done vital signs (blood pressure,</p>		<p>The policy <i>Falls, Assessment of Patient Post-Fall</i> includes review of patient medications, including anticoagulant/antiplatelet therapy. It states that the physician is to be informed immediately of a patient fall. The physician is to be informed of anticoagulant/antiplatelet therapy, and when requesting physician evaluation of the patient, that a request to hold anticoagulant/antiplatelet therapy be made. A recommendation for a head CT scan shall be made for suspected head injury. It states that the patient is to be examined by a physician. It states that for 72 hours after the fall, the patient shall be evaluated for any pain/symptoms related to the fall, including neurological signs for an unwitnessed fall and/or if patient hit head. Vital signs and neurological checks shall be done every 15 minutes x 4, every 30 minutes x 4, every 2 hours x 8, then every shift x 8.</p>	3/24/2015	

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	<p>pulse rate, temperature, respiratory rate readings) and neurological checks( bedside neurological exam that help determine level of consciousness, movement such as gait and sensation, pupillary eye responses that may indicate brain injury or brain bleeding due to a head injury) at the time of the fall. RN-1 said, "Yes." RN-1 was then asked if she had written the neuro checks down in the medical record. RN-1 said "No, we were transitioning to a new electronic medical record format that night."</p> <p>RN-1 was then asked if she was familiar with a nursing standard known as the Post Fall Assessment.</p> <p>RN-1 said "No, they never told me anything about that."</p> <p>Record review of Patient A's Patient Care Nursing Note written by Registered Nurse 2 (RN-2) on 7/24/12 at 4 AM indicated: "Patient alert complaining of slight pain on back of head...Pain medication offered but refused, call light within easy reach." The note did not address frequent neuro checks.</p> <p>RN-1 was taking care of Patient A after the fall up until 1:20 AM on 7/25/12. RN-2 came on at 11:30 PM, 7/24/12 helped RN-1 with the care of Patient A, then took over care of Patient A after 1:20 AM for the rest of the night.</p> <p>In interview on 10/1/12 at 1:45 PM RN-2 was asked what happened when Patient A fell.</p>			

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	<p>RN-2 said, " I took care of Patient A after the fall on the night shift. When I saw Patient A she was alert on my shift and said she was OK."</p> <p>RN -2 did not state if he had done additional neuro checks on Patient A after the fall that night.</p> <p>RN-2 was then asked if the RN was required to do a formal Post Fall Assessment that required sequential vital signs and neuro checks for every 15 minutes for one hour, request a mandatory physician exam, and medication review.</p> <p>RN-2 said "We do not do formal post fall assessments like they do in the nursing home. We do vital signs every four hours. I don't think any physician saw Patient A after the fall that night." RN-2 did not state he had done additional neuro checks every 15 minutes times 4, then: every 30 minutes times 4 then every 2 hours times 8 for Patient A after the fall.</p> <p>Record review of Patient A's Vital Sign Trend Report for 7/24/12 thru 7/26/12 indicated vital signs were taken at 8 PM (7/24), 1:30 AM, (7/25), and 4:32 AM (7/26). Patient A fell at 11 PM. There was no documented evidence that a formal Post Fall Assessment was done on Patient A immediately after the fall or during</p>			

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	<p>the night of 7/26/14, There was no documented evidence Patient A's Vital Sign Trend Report that serial neurological examinations were done after the fall.</p> <p>Review of a model Post Fall Assessment Protocol found in the Journal Nursing Care Quality (Vol.26, No 4, p.360 Copyright 2010) indicates nursing staff should have taken these following steps after the Patient A's fall: Additional considerations, potential head injury: Monitor mental status and vital signs Every 15 minutes times 4, then Every 30 minutes times 4, then Every 2 hours times 8"</p> <p>There was no documented evidence that this took place after Patient A fell and hit her head.</p> <p>Record review of Patient A's Patient Care Nursing Note written by Registered Nurse 3 (RN-3) on 7/26/12 at 10 AM indicated: "Ambulatory with standby assist, gait is steady, complaint of slight head pain, no nausea and vomiting." There was no documented evidence in RN-3's note that a neurological examination was done.</p> <p>In an interview, on 9/26/12 at 12:43 PM, RN-3 was asked what happened on the day after Patient A fell. RN-3 said "I took care of Patient A the day after the fall. This was the first time I took care of her. I knew there was a bump on the back of her head. She was ambulatory with assistance on my shift. I knew she had had a</p>		<p>The policy <i>Falls, Assessment of Patient Post-Fall</i> states that for 72 hours after the fall, the patient shall be evaluated for any pain/symptoms related to the fall, including neurological signs for an unwitnessed fall and/or if patient hit head. Vital signs and neurological checks shall be done every 15 minutes x 4, every 30 minutes x 4, every 2 hours x 8, then every shift x 8.</p>	3/24/2015	

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	<p>previous fall at home and could not use her walker adequately. Her daughter was here getting her ready for being discharged home. I thought she should be evaluated by the Physical Therapist (PT-1) to see if she needed any equipment at home."</p> <p>RN-3 was then asked if the RN was required to do a formal Post Fall Assessment the day after a patient fell in the hospital. RN-3 said "No, we just check vital signs and inform the attending physician about the fall." RN 3 did not state that she performed a neuro exam on Patient A.</p> <p>Review of Evidence-Based Geriatric Nursing: Protocols for Best Practice, 4th Edition, New York: Springer Publishing Company; 2011, Page 272 indicates, "Frequent neurological checks are done for several days following head injury in older patients who are on blood thinners or who have coexisting medical conditions to detect the development of serious conditions such as subdural hematoma. In addition, vital signs, assessing behavior, affect, cognition, and level of consciousness are all part of any assessment of the patient with head injury. Changes in speech, such as slurred speech, or subtle diminution of cognitive abilities (i.e., they no longer recognize you after recalling your name) are significant findings post fall head injury that require (sic) immediate attention. Older patients who have unwitnessed falls or do not recall falling despite evidence to the</p>			

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	<p>contrary should be monitored for head injury . Traumatic brain Injury(TBI) caused by head injuries is a condition that is preventable and, more importantly, readily recognizable. Subtle changes in cognition, level of consciousness, or behavior postfall indicate underlying head trauma. "</p> <p>There was no documented evidence that a physician had written a note or seen Patient A, after Patient A's hospital fall, on 7/24/12 11:00 PM up until 7/26/12 at 3 PM.</p> <p>Record review of Patient A's Physical Therapy Note written by Physical Therapist 1 (PT-1) on 7/25/12 at 2:45 PM indicated: "Family member reports patient had fall last night...Patient has marked decrease in proprioception (balance position-movement sensation) with ambulation, decreased use of right hand, increased fall risk discussed with RNs and Medical Doctor, unsafe for discharge home at this time..." This note was written 16 hours, 46 minutes after the fall.</p> <p>In an interview on 10/1/12 at 4 PM, PT-1 was asked what she noticed about Patient A during her exam on 7/26/12 at 2:45 PM after her fall. PT-1 said, " I saw Patient A before she was supposed to be discharged. I found her to be different in gait from when she was first admitted, I was aware of the fall the other night in the hospital. Patient A was not walking as good when I last saw her on 7/22/12 and</p>		<p>The policy <i>Falls, Assessment of Patient Post-Fall</i> states that the physician is to be notified immediately of a fall and that the patient is to be examined by a physician.</p>	<p>3/24/2015</p>

Event ID:KJCR11

2/26/2015

2:51:48PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/20/2012
NAME OF PROVIDER OR SUPPLIER  Seton Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Sullivan Ave, Daly City, CA 94016-2200 SAN MATEO COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	<p>7/23/12. She was not mentally alert like she was before. I told the physician and the Registered Nurses on duty she was not ready for discharge."</p> <p>Record review of a Physician' Progress Note, dated 7/26/12 at 3 PM, Indicated: "Patient had a fall last night and bumped her head per nurse patient was confused and has had Intermittent episodes of confusion today, did not ambulate well with PT today...small bump on scalp occipital area....conclusion: patient had fall last night- got head CT scan</p> <p>Record review of a Nursing Note, dated 7/26/12 at 4 PM Indicated: "Awake in bed, Alert and oriented B.P. (blood pressure) Increased 223/120...meloprolol 6 mg given (a medication to lower blood pressure)...6:30 PM B.P. rechecked...180/80 make go to CT scan...back from CT scan...B.P. 222/120...Neuro pupils unequal and eyes deviated to the side (indicator of brain Injury)...Rapid Response Team called...(medical emergency team -teams of health care providers such as a physician, nurse and respiratory therapist which respond to high acuity cases in an effort to decrease the risk of further deterioration)</p> <p>Record review of a Rapid Response Team Note dated 7/25/12 at 8:15 PM Indicated: "Reason for Call...Patient A had an acute change in conscious state..back from CT Scan...transfer to Critical Care Unit..."</p>			

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NAME OF PROVIDER OR SUPPLIER Seton Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Sullivan Ave, Daly City, CA 94015-2200 SAN MATEO COUNTY		
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	<p>Record review of a Critical Care Unit Nursing Note, dated 7/25/12 at 9:06 PM indicated: "Patient A Intubated by anesthesiologist...placed on ventilator..." (patient cannot maintain own airway, so patient is placed on breathing machine with breathing tube)</p> <p>Record review of a Neurosurgeon Consult Note, dated 7/25/12 at 11:31 PM Indicated: "The patient is seen for a an episode of intracranial hemorrhage (bleeding in the the brain)...On July 24, 2012 the patient had another fall while in the hospital. Since the fall that patient had difficulty with ambulation and was found intermittently confused. CT scan of the brain was performed and the study demonstrates a small area of hemorrhage in the right superior frontal region with extension of blood into the subdural space along the falx...I suspect this patient probably had a ruptured bridging vein in the medial aspect of the frontal parietal lobe on the right side resulting in a parenchymal hemorrhage as well as hemorrhage into falxine subdural space.</p> <p>Record review of a Neurology Consult Note, dated 7/26/12 at 10:41 AM, indicated: "I was kindly asked by the hospitalist to evaluate Patient A for a change in mental status...The patient during her stay had a fall on July 24, 2012 and a CT scan of the brain with contrast was done the next day during the night because of some problem with ambulation. This showed an acute subdural hematoma (A subdural hematoma is a collection of blood on</p>			

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NAME OF PROVIDER OR SUPPLIER  Seton Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Sullivan Ave, Daly City, CA 94015-2200 SAN MATEO COUNTY		
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	<p>the surface of the brain. Acute subdural hematomas are usually the result of a serious head injury the bleeding fills the brain area very rapidly, compressing brain tissue. This often results in brain injury and may lead to death.) overlying the right cerebral hemisphere...There is also an acute subdural hemorrhage overlying the right hemisphere...the patient this morning then became hypotensive with change in mental status...On physical examination, the patient is intubated, deeply comatose with no response to deep pain stimulation....Assessment: Comatose state (Individual in a comatose state is alive but unable to move or respond to his or her environment. Coma may occur as a complication of an underlying illness, or as a result of injuries, such as head injury) with dilated pupils related to increased intracranial pressure as related to intracranial bleed with subdural hematomas...the patient will have external ventricular drainage placement (a device used in neurosurgery that relieves raised intracranial pressure due to head injury and brain bleeding)...The patient's prognosis appears to be poor at this time."</p> <p>Record review of a Neurosurgeon Operative Note, dated 7/26/12 indicated; "Patient A had a episode of intracranial hemorrhage (bleeding in the brain) after an episode of falling on July 24, 2012. CT scan of the brain on July 26, 2012 demonstrated a small area of parenchymal hemorrhage in the right frontal region with extension of blood in the subdural space...On</p>			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/20/2012
NAME OF PROVIDER OR SUPPLIER  Sofon Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Sullivan Ave, Daly City, CA 94015-2200 SAN MATEO COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	<p>the morning of July 25, 2012 the patient experienced a sudden change in her condition. She became hypotensive (low blood pressure) and the right pupil became fixed and non-responsive. The patient became comatose...An emergent CT scan of the brain demonstrated extension of blood into the ventricles with obstructive hydrocephalus...Procedure...placement of external ventricular drain..."</p> <p>Record review of a Neurological Consult Note, dated 7/27/12 12 PM, indicated: "Cold caloric and apnea test done (cold water is injected into the ear to stimulate eye movement, done to look for brain damage in persons in a coma) no response...Patient is pronounced clinically brain dead at 12 AM."</p> <p>Record review of a Patient Care Note, dated 7/27/12 at 9 PM, indicates: "Code Status..DNR (Do Not Resuscitate -family or patient has indicated that they do not want CPR if heart stops)...Extubation, Family requests to have patient extubated (breathing tube and breathing machine removed because the patient is not likely to improve at which point the patient is allowed to die comfortably)...Patient extubated at 10:25 PM...Physician pronounced patient... time of death at 10:30 PM..."</p> <p>The hospital failed to ensure that an adequate Post Fall Assessment was conducted</p>			

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NAME OF PROVIDER OR SUPPLIER  Seton Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 Sullivan Ave, Daly City, CA 94016-2200 SAN MATEO COUNTY		
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	<p>Immediately and repeated frequently as per nursing standards of practice after Patient A's fall.</p> <p>The hospital's failure to ensure nursing staff conducted an adequate Post Fall Assessment on Patient A 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 Health and Safety Code 1280.1(c)</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>		<p>The <i>Fall Documentation</i> has been revised to reflect all elements of a complete PFA. It will be incorporated into the EMR in April 2015. Education pertaining to the new <i>Fall, Assessment of Patient Post-Fall</i> policy and the <i>Fall Documentation</i> PFA revisions will be provided to all acute care nurses, including those involved in the incident. Nurses unable to attend the in-services will be provided the information upon their return to work.</p> <p>All falls occurring on the 6<sup>th</sup> floor will be audited by the manager beginning March 26, 2015 to ensure that the <i>Fall Documentation</i> PFA was conducted immediately, and that the appropriate interventions specified in the PFA were implemented. The data will be presented to the Hospital PI and Patient Safety Committee monthly for 3 months. (See attachment B)</p> <p>Lynne Beattie, RN, Nurse Manager is responsible for the correction and monitoring.</p>	<p>3/24/2015</p> <p>4/15/2015</p> <p>3/26/15</p>

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