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
	050636	A. BUILDING _____ B. WING _____	09/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMERADO HOSPITAL	15615 POMERADO ROAD, POWAY, CA 92064 SAN DIEGO COUNTY

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	The following represents the findings of the California Department of Public Health during an investigation of Entity Reported Incident # CA00193150 Category: Accidents Representing the California Department of Public Health: [redacted], HFEN. Inspection of the facility was limited to the specific allegation(s) reported and does not represent the findings of a full inspection of the facility. Health and Safety Code 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. Title 22 Chapter 5 Division 1 Article 3 - 70213(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. Based on observation, interview, medical record review, and hospital policy/procedure review, the licensed nursing staff on the gero-psychiatric unit (GPU) health unit failed to implement the existing policy/procedures for one of one sampled patients, Patient P. On 6/20/09 Patient P was found by the licensed nursing staff in his room in a hospital style recliner chair that had fallen over backwards.		Plan of Correction: 1. Patients identified at risk for fall will have the guidelines in the Fall Prevention and Management procedure applied. (Attachment B1)	

Event ID:JPM711 11/25/2009 12:22:32PM

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Tim Greenwell for Chief Nursing Officer 12-10-09

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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	Continued From page 1 The usage of a "personal alarm" system was not present as indicated in the hospital fall management prevention policy, and after Patient P was found, there was no documentation in the medical record of notification to the physician. Findings: Patient P was admitted to the hospital on 6/18/09 into the gero-psychiatric unit (GPU). The physician history and physical dated 6/18/09 assigned a diagnosis that included dementia. On 6/19/09 the psychiatrist noted on the admission assessment that Patient P was also "gravely disabled." The nursing assessment done upon admission identified Patient P to be at high risk for falls with a point value of 80. In the hospital policy and procedure titled, Fall Prevention and Management (#17662) section B.1 directed the staff to use a personal alarm for any patients with an assessed fall risk point value greater than 45. On 6/26/09 the hospital [Hospital 1] administration reported to the Department that Patient P had fallen on 6/20/09. The report also noted that on 6/25/09, tests showed that Patient P had signs of bleeding into the brain. A physician ordered a CAT scan of the patient's brain which was done on 6/25/09. The radiology report dated 6/25/09 revealed that Patient P had bleeding into the right and left sides of the brain. Patient P was transferred to		Continued From Page 1 2. Staff assigned to GPU will be in-serviced on Fall prevention and Management procedure. (Attachment B2) Responsible Person: GPU Program Manager 3. GPU standards have been changed to reflect notification and documentation post fall of the attending physicians. (Attachment B3) 4. Charge nurse will be notified of any patient's fall. (Attachment B3) 5. De-briefing will be done after each fall to ensure that all elements of the, "Fall Prevention and Management" procedure	7/23/09

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	Continued From page 2 Hospital 2 on 6/26/09 and evaluated for further treatment. Patient P expired on 7/3/09. During an interview with Hospital 1's Chief Nursing Officer (CNO) on 7/9/09 at 8:30 A.M., the CNO stated that they were unaware that Patient P had expired on 7/3/09, and the report submitted to this office on 6/26/09 was based on the change of Patient P's condition. According to the nurses notes dated 6/20/09, Patient P was found on the floor at 4:00 A.M., and, " was sitting in a reclining chair with feet elevated and noted that chair had tipped backward. No apparent injuries." The nursing note documentation was absent of how and when Patient P was placed in the recliner chair, and there was no evidence in the nursing note/medical record documentation that the personal alarm was in place on Patient P prior to this incident. The hospital policy and procedure titled, Fall Prevention and Management (#17662) Section D.6. directed the GPU staff to notify the physician of the patient fall, circumstances of fall and the post fall assessment. There was no evidence in the nursing note documentation that the physician was notified of the patient's fall, the circumstances of fall, or a post fall assessment. The hospital policy and procedure titled, Fall Prevention and Management (#17662) Section E. directed the GPU staff to document physician notification of the fall, and what fall		Continued From Page 2 were followed to review what strategies could have been implemented to prevent the fall, to make sure the physician, family, or surrogate were notified and that documentation of such is complete if appropriate. (Attachment B4)	

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	Continued From page 3 prevention interventions were in place. There was no evidence in the nursing note/medical record documentation that the physician was notified, or what fall preventions interventions were in place. On 7/14/09 at 10:15 A.M., the GPU Program Manager (PM) was interviewed. The PM was asked if any of the required documentation related to contacting the physician was provided in the medical record of Patient P. The PM responded that there was no documentation that Physician 2 was notified. Additionally, the PM was asked if the use of the alarm system was an intervention for patients rated to be at high risk for falls. The PM stated that it would be "normal" to use the alarm intervention. Lastly, the PM was asked if any documentation was in the medical record of Patient P related to the use or activation of an alarm during the incident on 6/20/09. The PM could not identify any where in the medical record that the alarm system was in use or in place. On 7/9/09 at 10:00 A.M., observations were made of the recliner chairs that were in use on the GPU when Patient P had the accident. The GPU charge nurse identified two chairs that were currently in service. Although the specific chair could not be identified the GPU charge nurse stated that Patient P was in one of those chairs at the time of the accident. Subsequent inspection of both chairs revealed that the cross bars on both chairs, under the footrest,		Continued From Page 3 6. Weekly equipment serveillance is done as part of unit rounds with Program Manager or designee and follow-up as appropriate.	

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	Continued From page 4 were not intact. The documentation in the nursing notes related to the neurological assessments of Patient P did not reflect any significant changes in functioning from the day of admission 6/18/09 through 6/24/09. On 6/25/09 the licensed nursing staff documented that Patient P had become more lethargic. A physician ordered a CAT scan to be done on 6/25/09. The documented findings from the CAT imaging were provided in the radiology report dated 6/25/09 revealed Patient P had bleeding into the right and left sides of the brein. On 6/25/09, Patient P was transferred to the hospital's intensive care unit; then on 6/26/09 the patient was transferred to Hospital 2 for further evaluation and treatment. Physician 1's dictated discharge summary dated 6/26/09 provided that the bleeding into the brain was secondary to the fall from 6/20/09. The aforementioned notation was the first time in any of the physicians' documented notes that they were aware that Patient P had fallen on 6/20/09. Patient P stayed at Hospital 2 until 7/1/09 when he was transferred to a skilled nursing facility and expired on 7/3/09. On 7/17/09 at 1:50 P.M. Physician 2 was interviewed regarding Patient P and the 6/20/09 fall. Physician 2 stated that he had no recollection of being notified that Patient P had fallen on 6/20/09 and that no messages were		Continued From Page 4 Monitoring Plan: 1. The, "Patient Falls Quality Monitor" will be completed for every fall episode on the GPU. Continued monitoring will be integrated into the Quality Monitoring program for the GPU. (Attachment B5) Responsible Party: GPU Program Manager	7/23/09

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	Continued From page 5 received to that effect. The statement by Physician 2 corroborated that the licensed nursing staff failed to provide any documentation in the medical record that Physician 2 was notified. An autopsy was performed by the medical examiner on 7/4/09. The report concluded that Patient P's manner of death was accidental as a result of blunt head trauma. The facility's failure to implement the existing policy/procedure related to fall prevention, and the licensed nursing staff failure to provide notification to the physician that Patient P had fallen 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 section 1280.1 (c).			

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