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
	050604	A. BUILDING _____ B. WING _____	03/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL-SAN JOSE	250 HOSPITAL PARKWAY, SAN JOSE, CA 95119 SANTA CLARA COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
	The following reflects the findings of the California Department of Public Health during a facility reported event that resulted in an EMTALA (Emergency Medical Treatment and Labor Act) survey that was conducted on 3/19/08 to 3/21/08. Representing the California Department of Public Health: [redacted], Health Facilities Evaluator Nurse and Dr. [redacted] [redacted] Medical Consultant. Health and Safety Code 1280.1(a)(c) (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 twenty-five thousand dollars ($25,000) per violation. (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. DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY: Title 22, 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. Based on documentation and staff interview, the			

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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 hospital emergency department failed to provide stabilizing treatment to a patient with an emergency medical condition as defined by hospital policy. Findings: According to hospital policy (ED.13.02.02), each patient that enters the emergency department seeking medical care is given a priority based on an Emergency Severity Index (ESI) Coding System of priorities. Priority 1 is resuscitation requiring immediate intervention, Priority 2 is high risk and/or in severe distress requiring prompt intervention, Priority 3 is urgent requiring prompt medical attention, Priority 4 is semi-urgent in which no medical emergency exists and Priority 5 is no medical emergency exists. Additionally, hospital policy stated, "If an emergency medical condition exists, stabilizing treatment will be initiated in the ED...An emergency medical condition is such that the absence of immediate medical attention could reasonably be expected to result in: Placing the patient's health in serious jeopardy." Patient 1 presented to the hospital emergency room on March 6, 2008 at 8:26 p.m. According to the hospital triage note, the patient was complaining of "flu like symptoms", e.g., cough, weakness, fever, decreased appetite, and was initially assigned a priority level 3. A medical screening examination was conducted by Nurse A shortly after triage. The patient's medical history was obtained and a glucometer test (a test for blood sugar) was performed. The test was documented as "critical high." According to			

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	Continued From page 2 administration, the patient's blood sugar registered higher then the glucometer could record (>450 milligrams/deciliter (mg/del)). Hospital policy for glucose monitoring (PC.07.01) stated, "appropriate nursing actions will be taken whenever patient results exceed critical lab values which are: >450 mg/dl." In addition, the policy stated appropriate action includes, but is not limited to, repeating the test if the test result exceeds the critical lab values and notify the physician of results and consider requesting a laboratory blood draw. This policy was not implemented by nursing staff, but the patient was reclassified as a Priority 2, high risk needing prompt intervention. Nurse A informed the emergency department charge nurse (Nurse B) that Patient 1 needed to be roomed and seen. The emergency room had 25 treatment bays and all were full. Nurse B said he would work on opening up a room. Nurse A wheeled the patient back to the waiting room a few minutes after 8:41 p.m. The patient remained in the waiting room until approximately 9:50 p.m. when the patient's wife approached Nurse C stating her husband had "passed out" in his wheelchair. Nurse C felt a weak pulse but the patient did not respond to a sternal rub (method to elicit a patient response). Nurse C wheeled the patient back into the emergency department, finding an open room. Nurse B responded to the emergency, assessed that the patient's heart had stopped and began cardiopulmonary resuscitation (CPR). At 9:53 p.m., a medical code was initiated but resuscitative efforts failed. The patient expired at 10:04 p.m.			

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	Continued From page 3 On March 20, 2008, Nurse B was interviewed. As the charge nurse, it was his responsibility to ensure Patient 1 was assigned a room. According to Nurse B, Nurse A told him Patient 1 needed to be roomed. Nurse B stated at about the same time, another patient arrived via ambulance. While being brought into the emergency department, the arriving patient coded (stopped breathing). Nurse B stated he directed staff to place the patient in a room and assisted with the code. Nurse B's contact with Patient 1 occurred at approximately 9:53 p.m., when Nurse C called for help (one hour and nine minutes after being informed the patient needed prompt medical intervention). The nursing staff failed to implement the facility policy regarding prompt intervention of a patient with an emergency medical condition by placing Patient 1 back into the waiting room for over an hour without being monitored, and failed to notify the physician of a critical high blood glucose level. In addition, the hospital failed to develop a policy and procedure that provided direction to staff regarding where to place patients needing prompt medical intervention when the emergency treatment areas were full. The violation has caused or is likely to cause serious injury or death to a patient.			

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