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
	050551	A. BUILDING _____ B. WING _____	03/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ALAMITOS MEDICAL CENTER	3751 KATELLA AVENUE, LOS ALAMITOS, CA 90720 ORANGE 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 Department of Public Health during the investigation of COMPLAINT NO: CA00142374 Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the hospital. Representing the Department of Public Health: [redacted], HFEN 1280.1 (a) If a licensee of a health hospital 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 T22 DIV5 CH1 ART3- 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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Continued From page 1 The above regulation was NOT MET as evidenced by: Based on medical record review, staff interview, and review of policies/procedures, the hospital failed to ensure implementation of established patient fall policies resulting in death of a patient secondary to a fall in this hospital. Findings: Review of the hospital's policy "Fall Prevention," revealed the directive to use a safety belt on patients identified as being at low or high risk for falls when the patient was up in a chair or wheelchair. During interview on 3/12/08, staff stated that Patient #1, who was admitted to the geropsychiatric unit for behavioral problems, used a wheelchair to get to the dining room for meals. Staff disclosed that on 2/22/08, Patient #1 sustained a fall when he attempted to stand up from the wheelchair. On 3/12/08, the medical record for Patient #1 was reviewed. The record revealed Patient Care Flowsheets dated 2/13/08 through 2/22/08 identifying Patient #1 as a low to high risk for falls. On 2/14/08 at 1700 hours, the nurse documented that Patient #1 was able to sit in the dining room and follow cues. Review of nursing notes dated 2/17/08, revealed that Patient #1 was up in a wheelchair in the dining room for breakfast and dinner. On 2/19/08, the nurse documented that			

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	Continued From page 2 Patient #1 was "out for dinner but refused to eat much 20%." On 2/21/08, the nurse documented Patient #1 was in the dining room for breakfast and lunch. The nursing documentation from 2/13/08 through 2/22/08 failed to show evidence that a safety belt was utilized when Patient #1 was up in a chair or wheelchair as per policy. Nursing documentation dated 2/22/08 at 1100 hours, documented that Patient #1 was in a group activity sitting up in a wheelchair facing the table. Review of the nursing documentation for 2/22/08 failed to show evidence that a safety belt was utilized when Patient #1 was up in a chair or wheelchair as per policy. The nurse documented Patient #1 tried to get up from the wheelchair, lost his balance, and hit his head on the table. Medical record review revealed CT/MRI scan results dated 2/22/08 documenting Patient #1 had a "severe acute large left subdural hemorrhage causing a large midline shift/transfalcine herniation and downward herniation as well, with loss of the suprasellar cistern." A discharge summary documented that Patient #1 was admitted to the Intensive Care Unit on 2/22/08 and expired on 2/23/08. In this discharge summary, the physician documented that Patient #1's death was "secondary to acute bleed secondary to fall, secondary to exacerbation by anticoagulation in a patient with renal insufficiency." The violation(s) has caused or is likely to cause, serious injury or death to the patient(s).			

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