## CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF PUBLIC HEALTH

NAME OF PROVIDER OR SUPPLIER LOS ALAMITOS MEDICAL CENTER  STREET ADDRESS, CITY, STATE, JIP DODGE  THOROGER'S ILAND OF CORRECTION  SUMMARY STATEMENT OF DEPTICIENCES  STREET ADDRESS, CITY, STATE, JIP DODGE  THOROGER'S ILAND OF CORRECTION  (EACH OERGOENCY WASOT BE PRECEEDED BY I'LL  REQUILATORY OR ISC IDENTIFYING INFORMATION)  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:  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 for patient care shall be developed, maintained and implemented by the nursing service.  Event ID:08L511 8/14/2008 2-04-06PM	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
CAS ALAMITOS MEDICAL CENTER   3751 KATELLA AVENUE, LOS ALAMITOS, CA 90720 ORANGE COUNTY	05		050551	050551				03/12/2008	
PRETIX TAG    PRETIX   (EACH DEPICIENCY MUST ARE PRECEDEDED BY PILL   PRETIX RESULATORY OR LSC IDENTIFYING INFORMATION)   PRETIX TAG   PRETIX REFERENCED TO THE APPROPRIATE DEFICIENCY)   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:									
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE			ER/SI IDDI IED DEDDESE				TITLE		(X6) DATE

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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## CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050551		(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/12/2008	
						03/1		
NAME OF PROVIDER OR SUPPLIER  LOS ALAMITOS MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  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 (EACH CORRECTIVE ACTION REFERENCED TO THE APPR	ON SHOULD BE CROSS- COMPLETE		
	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 med reviewed. The reflowsheets dated identifying Patient #1 On 2/14/08 at 1700 that Patient #1 was and follow cues. Re 2/17/08, revealed the wheelchair in the dinner. On 2/19/08, the	ecord revealed P 2/13/08 through as a low to high r hours, the nurse able to sit in the eview of nursing nat Patient #1 was lining room for br	atient Care 2/22/08 risk for falls. documented dining room notes dated s up in a eakfast and					
Event ID:		_	8/14/2008		06PM			
LABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESE	NTATIVE'S SIGNAT	ΓURE	TITLE		(X6) DATE	

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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).							
	serious injury or death	to the patient(s).						
Event ID:I			8/14/2008		06PM			
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