

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2008
NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF CALIFORNIA IRVINE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CITY DRIVE SOUTH ROUTE 153, ORANGE, CA 92868 ORANGE 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>Continued From page 1</p> <p>Patient X. The hospital failed to ensure the nurse advocated for Patient X's safety. Patient X sustained a fall resulting in bleeding in the brain. As a result of brain death, the patient was taken off life support and died.</p> <p>Findings:</p> <p>On 6/24/08 at 1600 hours the hospital's self report of a death related to a fall was investigated. The administrative staff stated a medical student witnessed Patient X fall at 1344 hours on 6/11/08 and went to the room to assist. When the patient's son arrived to interpret, the patient stated that the fall happened when reaching for the sink on the way to the bathroom. The registered nurse (RN #1) assigned to the patient was off the nursing unit while discharging another patient at the time of Patient X's fall. Patient X's family was not in the room at the time the patient got up from bed and fell.</p> <p>On 6/24/08 the hospital's P&P for fall prevention included the following for patients at high risk for falls:</p> <p>Communication of the fall risk to the patient and family. Instruct patient and family using Fall Prevention Teaching Plan. Check for availability of patient room close to the nurses' station for increased observation, if indicated. Colored footwear (red) to identify a patient at risk for falls to all hospital staff. Interventions aimed at making a safe environment</p>		<p>An immediate action was taken to address the deficiency related to the failure to ensure the nursing staff implements the fall prevention policy and procedure and plan of care for patients at high risk for fall by re-education of the Progressive Care Unit (PCU) staff. Re-education was done through:</p> <ul style="list-style-type: none"> • In-services • Monthly staff meetings • Creation of a Fall Resource book that contains the policy, example of teaching plan and example of plan of care. The Nurse Manager was responsible for re-education of the PCU staff. 	<p>7/01/08 6/08, 7/08, 8/08 7/08</p>

Event ID:MC8G11

12/19/2008

2:19:38PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2008
NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF CALIFORNIA IRVINE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CITY DRIVE SOUTH ROUTE 153, ORANGE, CA 92868 ORANGE 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>Continued From page 2</p> <p>while meeting the patient's basic physiologic needs. Initiate "Injury High Risk for: Falls" patient outcome plan with individualized interventions.</p> <p>At 1740 hours on 6/24/08 interview with RN #1 revealed that when returning from discharging another patient they were informed Patient X fell and sustained a laceration to the back of the head. RN #1 stated they did not let the other nursing staff know they were gone from the unit so they would know to watch the patients. RN #1 could not remember if the patient's call light was on when they returned to the nursing unit. The curtain to Patient X's bed was probably pulled closed from the head of the bed to the foot of the bed. RN#1 revealed there was a bedside commode next to Patient X's bed. The patient had used the commode in the past but did not use it during this instance. There was no walker at the patient's bedside. RN #1 stated they did not remember if Patient X had non-skid red socks on throughout the day shift of 6/11/08 and/or at the time of the fall. RN #1 stated communication with Patient X was difficult due to a language barrier. Patient X communicated by pointing to objects when the family was not in the room. Patient X had refused to use the cardiac monitor and the anticoagulant medication on 6/11/08 by gesturing and saying "no."</p> <p>At 1715 hours on 6/24/08 observations of the room where Patient X fell and the nursing unit were conducted. Patient X's room was observed to be by the nurses' station; however, the bed where the</p>		<p>Chart audits of 100% of patients who are high risk for fall were conducted by Nurse Manager or designee starting August 2008 relative to adherence to Fall Prevention Program. Audits continued until September 2008.</p> <p>Based on audit results, staff were re-educated in October 2008.</p> <p>Random audits of patients in PCU who are high risk for falls are continuously conducted and will be shared at monthly meetings between directors and managers until sustainability of compliance is maintained.</p> <p>The fall prevention policy was revised to include specific interventions based on Lippincott Manual of Nursing Practice.</p> <p>A Computer Based Training was developed to re-educate the inpatient nursing staff and ancillary department staffs of the Fall Prevention Program.</p> <p>A resource book for nurses on the fall prevention planning was developed and distributed to inpatient units.</p>	<p>09/30/08</p> <p>10/08</p> <p>Ongoing</p> <p>11/17/08</p> <p>02/09</p> <p>11/08</p>

Event ID:MC8G11

12/19/2008

2:19:38PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2008
NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF CALIFORNIA IRVINE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CITY DRIVE SOUTH ROUTE 153, ORANGE, CA 92668 ORANGE 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>Continued From page 3</p> <p>patient was placed could not be seen because the privacy curtain was pulled. Staff stated this curtain was usually pulled for the patient's privacy and that you could not visualize the patient until they got to the foot of the bed. Several patients were identified as being on fall precautions by the falling star at the door to the room. Adaptive equipment (bedside commodes and walkers) for the patients were not within their reach from the bed. The nursing staff and manager for the unit stated that the equipment would not be left at the patient's bedside unless Physical Therapy had determined that it was safe for the patient to ambulate alone. The patient was expected to call the nurse for help and then the equipment would be provided.</p> <p>On 6/24/08 at 1630 hours, the medical record for Patient X was reviewed. The record showed Patient X was admitted to the hospital on 6/6/08. Admission orders included an anticoagulant (medication to prevent blood from clotting too much). The nursing admission assessment identified a fall risk due to decreased function of both legs and assistance needed while walking. The assessment indicated the patient did not speak English and the family would be used for interpretation. The care plan developed for Patient X did not identify a means to communicate with the patient if the family was not present. The nursing care plan did not indicate how, and in what language, the patient would be taught about the fall risk and safety measures. A care plan for falls was initiated and included the following interventions: Implement fall prevention program and teaching plan.</p>		<p>An immediate action was taken to address the deficiency related to the failure to identify individualized patient teaching plan was addressed by re-education of the PCU staff. Re-education included communication of fall risk and safety precautions to patient and family. Fall education will be documented in the teaching plan. For non-English speaking patients, ATT or an interpreter will be used to educate patient. Staff members who are fluent in the patient's language and patient's family members who can translate will be also used as a resource in communicating with patient(s). The Nurse Manager was responsible for re-education of nursing staff.</p>	7/01/08

Event ID:MC8G11

12/19/2008

2:19:38PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2008
NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF CALIFORNIA IRVINE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CITY DRIVE SOUTH ROUTE 153, ORANGE, CA 92868 ORANGE 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>Continued From page 4</p> <p>Remind patient to ask for assistance. Non-skid footwear and bedside commode. Initiate OT/PT referral to improve gait/balance.</p> <p>The teaching plan developed for Patient X failed to identify the need to teach about the patient's individualized risk for falls and safety precaution measures. There was no documented evidence the patient or family were taught about the risk for falls and safety measures to be taken. All other teaching provided by the nursing staff was documented as "barrier to learning present."</p> <p>Documentation by the Occupational Therapist on the Patient Outcome Plan identified that on 6/10/08 there was no further need for therapy and nursing was to encourage the patient to maintain the activity level. On 6/10/08, Physical Therapy documented in the Daily Treatment Note that the patient required minimal assistance to ambulate with a front wheeled walker (FWW) and that without the device the patient was at risk for falls. Use of the FWW was not added to the patient's care plan. There was no documented evidence a FWW was left at the patient's bedside for use when ambulating.</p> <p>On 6/11/08 there was no documented evidence the patient had non-skid (red) socks applied. There was no documented evidence that a walker was left in the room for the patient's use. The Nurses Notes documented that at 1344 hours on 6/11/08 Patient X attempted to ambulate to the bathroom and fell to the side and back. The patient was oozing blood from the head and tailbone. The surgical team was</p>		<p>Chart audits of 100% of patients who are high risk for fall were audited by the Nurse Manager (or designee) starting August 2008 relative to presence of a teaching plan. Audits continued until September 2008. Based on audit results, staff were re-educated in October 2008.</p> <p>Random audits of patients in PCU who are high risk for falls are continuously conducted and will be shared at monthly meetings between directors and managers until sustainability of compliance is maintained.</p> <p>A patient education brochure for patient and family was developed.</p> <p>The deficiency related to the failure to include front wheeled walker was addressed by re-education of the PCU staff. The re-education included incorporating the Physical Therapist and/or Occupational Therapist's recommendations into the Nursing Care Plan. The Nurse Manager was responsible for re-education of the PCU staff.</p> <p>An immediate action was taken to address the deficiency related to the failure to ensure that nurse advocate for patient safety was addressed by re-education of the PCU staff. The staff was re-educated to advise another staff member if they go off the floor for any reason. The Nurse Manager was responsible for re-education.</p>	<p>09/08</p> <p>10/08</p> <p>Ongoing</p> <p>11/08</p> <p>12/29/08</p> <p>08/08</p>

Event ID:MC8G11

12/19/2008

2:19:38PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/24/2008
NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF CALIFORNIA IRVINE MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 CITY DRIVE SOUTH ROUTE 153, ORANGE, CA 92868 ORANGE 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>Continued From page 5</p> <p>at the bedside. Physician documentation showed the patient hit the head during the fall. At 1430 hours the patient complained of severe head pain. Pain medication was given and the patient was taken for a CAT scan of the head. The CAT scan showed the patient had bleeding in the head. At 1530 hours the patient's blood pressure fell and subsequently the patient became unresponsive. The patient required mechanical ventilation and medication to maintain an adequate blood pressure. A repeat CAT scan showed increased bleeding in the brain and the patient was taken to surgery at 1630 hours. The patient did not regain consciousness. The patient was taken off life support on 6/13/08 and died.</p> <p>The hospital failed to ensure a care plan was developed to address the patient's individualized needs for nursing care. The hospital failed to ensure implementation of the fall prevention protocol by the nursing staff caring for Patient X. The hospital failed to ensure Patient X was taught about the risk for falls and safety precautions in a language understood by the patient. The hospital failed to ensure adaptive equipment needed for the patient to safely ambulate was available at the bedside. The hospital failed to ensure the nurse advocated for the patient's safety by telling other staff when leaving the unit.</p> <p>The violation(s) has caused or is likely to cause, serious injury or death to the patient(s).</p>				

Event ID:MC8G11

12/19/2008

2:19:38PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.