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
	050243	A. BUILDING _____ B. WING _____	04/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT REGIONAL MEDICAL CENTER	1150 N Indian Canyon Dr, Palm Springs, CA 92262-4872 RIVERSIDE 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 an inspection visit:

Complaint Intake Number:
CA00244689 - Substantiated

Representing the Department of Public Health:
Surveyor ID # 28294, HFEN

The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.

Health and Safety Code Section 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.

Abbreviations used in this document:

CM - Clinical Manager
CT - Computerized tomography (A radiographic technique that selects a level in the body and blurs out structures above and below that plane, leaving a clear image of the selected anatomy.)
Pt - Patient
RN - Registered Nurse
SNF - Skilled Nursing Facility
Stat- Immediately
& - and

Health and Safety Code Section 1279.1 (c): "The facility shall inform the patient or the party

The plan of correction is prepared in compliance with federal regulations and is intended as Desert Regional Medical Center's (the "hospital") credible evidence of compliance. The submission of the plan of correction is not an admission by the facility that it agrees that the citations are correct or that it violated the law.

Organization Minutes:
The confidential and privileged minutes are being retained at the facility for agency review and verification if required.

Exhibits:
All exhibits including revisions to Medical staff Bylaws, reviewed/revised or promulgated policies and procedures, documentation of staff and medical staff training/education are retained at the facility for agency review and verification upon request.

CA DEPT OF PUBLIC HEALTH
2014 APR -1 PM 12:21
LICENSING & CERT.
RIVERSIDE COUNTY

4/1/14

Event ID:05XK11 3/25/2014 2:42:12PM

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

DSOI 3-28-2014

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s). 1 thru 7

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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responsible for the patient of the adverse event by the time the report is made."

The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made.

Title 22 of the California Code of Regulations section 70251(b):

Planning and Implementing Patient Care

(b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission.

Based on interview and record review, the facility failed to follow the physician's order to ambulate Patient 1 with assistance and failed to initiate a fall/injury plan of care after the patient was identified on assessment to be at risk for a fall/injury. A facility staff member witnessed Patient 1 ambulating in her room without assistance and left the patient's room. Patient 1 fell, sustained a subdural hematoma (bleeding around the brain), and died seven days later.

Findings:

On October 12, 2010, the record for Patient 1 was reviewed. Patient 1 was admitted to the hospital on [redacted], 2010, at 2:50 p.m., with diagnoses

Tag: Title 22 of the California Code of Regulations Section 70251 (b) Health and Safety Code Section 1280.1 (c)

Policy & Procedures:
The Director of the Nursing Unit, in conjunction with the Director of Quality, the Director of Risk Management, and the Chief Nursing Officer, reviewed the Fall Prevention Program and Post Fall Care Policy. The policy met the current standards of care and no revisions were required. 10/01/2010

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	including symptomatic anemia (deficiency in the amount of oxygen carrying capacity of the red blood cells resulting from another disease). Patient 1 was admitted to the facility for a transfusion of three units of packed red blood cells for the treatment of the symptomatic anemia. The physician's History and Physical, dated [redacted] 2010, indicated Patient 1 was "currently alert and oriented and in no apparent distress at this time... Past Medical History: 10. History of multiple mechanical falls (falls resulting from the environment to include slips, trips, and loss of balance)." The Hospitalist Admission Orders, dated [redacted] 2010, indicated: "Ambulate w/Assist." The "Clinical Documentation - Patient Assessment MORSE (rapid and simple method of assessing a patient's likelihood of falling)/BRADEN (method of predicting pressure sore development risk)" dated [redacted] 2010, at 7:50 p.m., indicated "Morse Fall Risk Score - 50." A "Morse Fall Risk Score of 45 & above" indicated the patient was at a "High Risk" for fall or injury. The facility Policy and Procedure entitled, "Fall Prevention Program and Post Fall Care," with a revised date of March 2010, indicates the following: "It is the policy of (facility name) to assess inpatients for risk of falls. Furthermore, fall prevention interventions will be applied to patients based on the score of the risk assessment tool." Under Procedure #2 the policy further indicated: "Patients are risk stratified into no		**Training:** The Nursing Staff for the Unit were in serviced on several key items for fall prevention including the following: appropriate and accurate assessment of fall risks using the Morse Scale Score, as well as interventions based on that assessment; the importance of medical record review for vital information regarding the patient; updated and accurate care plan; and handoff communication using the SBAR tool. The in-service was conducted by the Nursing Director and Clinical Manager on 10/12/2010, 10/14/2010, 10/15/2010, 10/19/2010, and 10/22/2010 A roving in-service on the Hill Rom bed alarm for patient safety/fall prevention was conducted throughout the Nursing Units on 10/27/2010. The Nursing Director facilitated this in-service conducted by the Hill Rom Representative. This information was incorporated into new nursing employee orientation and annual reorientation. **Monitoring:** A Fall Investigation Report Form was implemented on 10/1/2010 to be completed on all falls. This was monitored by The Director of Risk Management Falls are monitored via an electronic incident reporting system and Fall Investigation Report Form by the Director of Risk Management 10/1/2010 and ongoing.	10/31/2010 10/31/2010 10/31/2010 ongoing 11/20/2010

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	risk, low risk or high risk category based on the initial score from the Morse Fall Risk Assessment Tool." Under Procedure #5, the policy indicated: "If it is determined the patient is a low or high risk for falls, a fall prevention plan of care is initiated as a primary problem." Physician Orders, dated [redacted] 2010, indicated: "Transfer back to Skilled Nursing Facility." Patient 1 was to be discharged from the facility less than 24 hours after admission. A Clinical Documentation - Nursing Note, dated [redacted] 2010, at 4:09 p.m., indicated: "Found patient laying on the floor after hearing "thud." Pt holding head and crying." On October 12, 2010, at 10 a.m., an interview was conducted with Clinical Manager 1 (CM 1). She stated before 4 p.m., on [redacted] 2010, Patient 1 was pacing back and forth at the foot of her bed saying, "I have to go." CM 1 stated Patient 1 was agitated and was waiting to be transferred back to the skilled nursing facility (SNF) because it was her wedding anniversary and a special dinner for her and her husband was to take place. CM 1 stated she left Patient 1's room, went to the nurses' station, picked up the telephone, and this was when she heard a "thud" coming from Patient 1's room. CM 1 stated she went back into Patient 1's room and she found Patient 1 lying on her right side holding her head and crying. On April 20, 2011, at 10 a.m., an interview was conducted with CM 1. She stated the physician's		Fall Reduction Program Compliance Audit was completed on 10/21/2010, 10/30/2010, and 11/19/2010 demonstrating 100% compliance for the indicators. This was facilitated by the Nursing Director and the Clinical Manager. The results of the audits were reported to the Quality Council, the Medical Executive Committee and the Governing Board at their regularly scheduled meetings for review and action as required. **Other Corrective Actions:** A Fall Reduction Improvement Team, under the guidance of the Director of Risk Management and the Director of Quality, commenced on December 14, 2010 Subsequently a Falls Champion was designated, Staff education continued, random audits were completed, the Policy was revised, signage was piloted then implemented, and Care Plan Form was revised to reflect Morse Scale Score more accurately **Responsible Person(s):** Chief Nursing Officer, Nursing Director, Clinical Manager, Director of Risk Management, Director of Clinical Quality Improvement.	12/31/2010

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	order "Ambulate w/Assist" meant someone needed to be in the room with the patient if the patient was out of bed and ambulating. CM 1 stated she had been in the room shortly before Patient 1 fell. She stated she was unaware that the patient had an order to ambulate with assist because she was not assigned that patient, and if she had known the patient had an order for "Ambulate w/Assist" she would not have left the patient in the room alone pacing back and forth. The patient did not have a Fall/Injury Plan of Care initiated. The Patient's medical record included a preprinted, "Interdisciplinary Plan of Care," dated [redacted] 2010 through [redacted] 2010, however the areas for Fall/Injury were not filled in with "Date Initiated, Focus, Expected Outcomes, Interventions, and Date Resolved." There were no fall risk plans of care initiated for Patient 1. On April 20, 2011, at 10 a.m., CM 1 reviewed the record for Patient 1 and was unable to find documentation of a "Fall/Injury" plan of care. CM 1 stated there should have been a plan of care initiated for "Fall/Injury" because of the patient's Morse Fall Risk Score. She was unable to state why this had not been completed. On April 20, 2011, at 10:20 a.m., an interview was conducted with RN 1. RN 1 advised if the Morse Fall Risk Score was 25 or greater for a patient, she would have expected to see a plan of care for fall/injury based on the patient's score documented in the medical record. In addition, RN 1 stated a physician's order for "Ambulate w/Assist" meant		**Disciplinary Action:** Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.	

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the patient was not safe to be up by themselves. RN 1 advised if the patient was up and ambulating, someone needed to be with the patient.

A Physician Order, dated [redacted] 2010, at 4 p.m., indicated "CT Head - Stat."

A "Diagnostic Imaging - CT Head or Brain w/o (without) Contrast," dated [redacted] 2010, at 5:09 p.m. indicated: "There is evidence of acute subdural hematoma (severe bleeding into the brain);" and "Large scalp hematoma overlying the occipital bone is identified."

The Clinical Documentation - Adult Admission Assessment, dated [redacted] 2010, at 12 a.m., indicated Patient 1 was "Lethargic, Excessive Sleep, No vocalization, frowning, Disoriented to person, Disoriented to place, Disoriented to situation, Disoriented to time."

Physician Orders, dated [redacted] at 12:30 a.m., indicated: "Stat CT Head (without) contrast."

A Diagnostic Imaging - CT Head or Brain w/o (without) Contrast dated [redacted] 2010, at 1:39 a.m., indicated: "Significant interval increase in the left subdural hematoma as described, with new intraparenchymal (essential parts of an organ) hematoma in the left high frontoparietal lobe (front of brain)."

Patient 1 was transferred to a SNF on [redacted] 2010, with hospice care due to "blossomed" subdural hematoma, unable to follow commands,

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	and "unable to grip." Patient 1 died on [redacted] 2010, at 11:53 a.m. [redacted] This facility failed to prevent the deficiency(ies) as described above that 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).			