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
	050636	A. BUILDING _____ B. WING _____	02/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMERADO HOSPITAL	15615 POMERADO ROAD, POWAY, CA 92064 SAN DIEGO 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 a complaint/adverse investigation visit: Complaint Intake Number: CA00217096 - Substantiated Representing the Department of Public Health: [redacted] 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. 70215 Planning and Implementing Patient Care. (a) (3) (b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnoses, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission. This Rule is not met as evidenced by: On 1/31/10 a patient with a documented history of confusion and agitated behavior was left unattended by facility staff. The patient got out of bed, fell to the floor fracturing his skull in several places. The		Action: Fishbone diagram completed as an exercise by leadership and staff to identify causes/potential causes of falls. Outcomes: Five main categories identified and prioritized by the team: communication, patient, staff, equipment and education with actions taken to address each category. Cheat sheets developed for activating bed exit alarms placed on versacare beds. Secured to each versacre bed frame for reference. Two gait belts available on units for staff use. Four additional walkers ordered and received. Rubber stoppers applied to bedside commode and shower chairs. Interdisciplinary rounds every Tuesday with -Fall risk emphasis, reviewing standard of Morse Fall Risk Scale >45 puts patient at risk and to implement care plan.	2/6/10

RECEIVED
CA DEPT OF PUBLIC HEALTH
JUN - 9 2010
LICENSING & CERTIFICATION
SAN DIEGO NORTH DISTRICT OFFICE

Event ID:LQQ711 5/26/2010 3:36:41PM

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

Mana Judak for Ken Colonnelli Chief Nursing Officer June 8, 2010

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 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 date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050636	A. BUILDING _____ B. WING _____	02/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMERADO HOSPITAL	15615 POMERADO ROAD, POWAY, CA 92064 SAN DIEGO 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
	Continued From page 1 patient also suffered bleeding within his brain. The patient's condition declined, and he died four (4) days later. Patient A's plan of care was initiated on the day of admission when it was noted that he was at high risk to fall. Documentation and interview revealed multiple attempts and occurrences of Patient A getting out of bed unassisted. The facility used the patient's son and on one occasion a volunteer to assist in the observation of Patient A. The facility policy directed staff to use restraints as the next intervention. However, staff did not feel that the use of restraints was an appropriate measure. The staff failed to implement alternative measures such as a continuous 1:1 sitter to provide for Patient A's safety. Findings: Patient A was admitted to the facility's medical surgical floor with telemetry and an order for bed rest on 1/27/10. According to the history and physical (H&P) Patient A had experienced increased shortness of breath and possibly pneumonia and was admitted for further work up. The H&P also noted Patient A had severe dementia. The nursing documentation indicated that Patient A was confused, agitated, pulling out his IV and pulling off his cardiac monitoring leads. The admission fall risk assessment documented Patient A to be a fall risk with a score of 50. According to the facility's Fall Prevention and Management policy patients scoring 45 or greater are at a high risk to fall.		Continued From Page 1 Inpatient Director, CNS, and staff member, Kathryn Putroff visited Safe Unit at Scripps Mercy Hospital to review patient safety strategies and fall prevention process. Educated all staff on correct use of tab alarm 2/9-2/18 (Dolores Sandovol (staff), CNS and Supervisors. Person Responsible: Director of Adult Inpatient Services, Maria Sudak, Eva Krall Unit Clinical Nurse Specialist with Medical Surgical staff participation. Ongoing Action as part of the fall prevention program: Action: Annual Restraint Competency to include learning module and return demonstration. Monitoring Process: Successful completion and demonstration by each staff RN and CNA.	2/10/10 2/18/10 3/2010

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050636	A. BUILDING _____ B. WING _____	02/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMERADO HOSPITAL	15615 POMERADO ROAD, POWAY, CA 92064 SAN DIEGO 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
	Continued From page 2 Patient A was admitted to Room 314 on 1/28/10 and a CNA [certified nurse's aide] was utilized as a sitter for the patient. The patient was moved to Room 307, which was closer to the nursing station, and the CNA was released from being utilized as a sitter for Patient A. In an interview on 2/12/10 with Registered Nurse [RN 1] who provided care to Patient A on 1/28/10, RN 1 confirmed that Patient A had been moved, and the CNA had been released from sitting in the patient's room. According to the documentation from RN 1, on 1/28, Patient A tried to get out of bed without calling and was unsteady on his feet. RN1 stated all fall precautions were in place, including tab and bed alarms, rounds for observation, and moved closer to nurse's station. A review of the physician orders indicated medications were ordered for Patient A due to anxiety/agitation and sundowning (a state of increased agitation, confusion, disorientation, and anxiety that typically occurs in the late afternoon or evening). The medications ordered included Ativan (antianxiety agent), Haldol (major tranquilizing agent), and Zyprexa (atypical antipsychotic). Adjustments to the medications were made on 1/29 and 1/30. Review of the physician progress notes on 1/29 indicated Patient A "Had received Ativan last night, apparently hitting the nurses..." On 1/30/10, the physician noted Patient A was "still sun downing last night, Zyprexa given...with no effect." On 1/30/10, licensed staff documented at 2:17 a.m.		Continued From Page 2 Person Responsible: Clinical Nurse Specialist Action: NICHE (Nurses Improving the Care of Health System Elders) training, classes provided based on standardized curriculum and presented by Jackie Close Gerontology Certified Clinical Nurse Specialist. Outcome: Second group Medical Surgical RNs to complete NICHE training. 18 RNs on MedSurg now trained in elder care to act as consultants to peers. Person Responsible: Medical Surgical Staff Action: Toileting Program for elderly demented patients developed by Grad Student Spring 2010. Shared with Unit Practice Council for approval 5/2010 and distribution/education of peers. E mail out via Director to Medical Surgical Care Team and discussions during May 2010 staff meeting.	5/14/10 6/30/10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050636	A. BUILDING _____ B. WING _____	02/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMERADO HOSPITAL	15615 POMERADO ROAD, POWAY, CA 92064 SAN DIEGO 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
	Continued From page 3 that Patient A was anxious, uncooperative, pulling out IV, pulling off cardiac monitor leads, and trying to get in and out of bed. The documentation indicated that Patient A had to be redirected to go back to bed. According to the nursing documentation, on 1/30/10 at 10:00 a.m., the nursing staff called the son to come to the facility and stay with Patient A, as he was restless and uncooperative. The son left at 2:00 p.m. and according to the nursing notes the patient was put in a wheelchair close to the nursing station with a volunteer watching him, and then was put back to bed and the volunteer released. At 5:30 p.m. that evening, according to nursing documentation the patient was uncooperative, very anxious and trying to get in and out of bed. At 7:25 pm the same evening, according to the nursing documentation Patient A got out of bed without his gown on, was very confused and agitated and had to be assisted back to bed. On 1/31/10, at 7:40 p.m., a late entry was documented by nursing. According to the nursing documentation Patient A was uncooperative early in the shift[FN1], confused, anxious and trying to get out of bed. According to the documentation, Patient A was re-directed to go back to bed. On 1/31/10 at 9:40 a.m., Patient A got out of bed and fell on the floor. The CT (computerized tomography) of the brain done on 1/31/10 at 10:02 am, showed small areas of post traumatic subarachnoid blood (blood between two membranes surrounding the brain) within the		Continued From Page 3 Monitoring Process: Monthly x3 during Tuesday Interdisciplinary Rounds then quarterly x4. Person Responsible: Rounding audits by unit Supervisors and Jackie Close, Gerontology CNS. Action: Subgroup of Pomerado Action Committee (PAC) an interdisciplinary team consisting of Nursing, Physical Therapy, Staff, Environmental Services developing a "new look" in fall leaf signage as well as staff and patient education. Person Responsible: Eva Krall, MedSurg CNS, in joint effort with interdisciplinary PAC team Action: Post fall huddles in SBAR format completed by unit Supervisor/Releif Charge RN during shift of fall with staff involved. Post Fall Huddle Form revised with staff feedback.	7/2010 2/10/10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050636	A. BUILDING _____ B. WING _____	02/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMERADO HOSPITAL	15615 POMERADO ROAD, POWAY, CA 92064 SAN DIEGO 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
	Continued From page 4 bilateral temporal regions. The repeat CT (done 6 hours later) showed increased left subarachnoid bleeding with new bifrontal intraparenchymal bleeding (bleeding within the brain tissue) and noted fractures in the left temporal bone and left parietal bone. Patient A's level of consciousness declined and the patient was discharged on 2/2/10 on Hospice care, where he died two days later on 2/4/10. RN 2, the care provider for Patient A on the day of the fall (1/31/10) was interviewed on 2/12/10. According to RN 2, Patient A had fall precautions in place, including a tab alarm, which the patient removed, as well as a bed alarm. RN 2 stated that following the patients' fall, she had asked the supervisor why a sitter was not used for Patient A. According to RN 2 the supervisor told her there were a hundred other things to do before utilizing a sitter. The charge nurse (CN) on the day of the fall was also interviewed on 2/12/10. According to the CN, Patient A would take the tab alarm off, and ambulate to the bathroom unattended. The CN stated that they would have had a sitter if one was available, but 9 out of 10 times there aren't sitters available, and they just didn't have enough staff for the patient. On 2/12/10, administrative staff was interviewed regarding the facility's policy and procedure on obtaining a sitter. The facility provided a policy entitled Patient Observation Assistant (POA) Use		Continued From Page 4 Monitoring Process: 100% post huddle forms for patient falls are reviewed by unit CNS to identify opportunities for improvement in patient safety and fall prevention on an on going basis. 90% of the elements on the post fall huddle form will be completed: Situation-time, location, possessions near by bed exit alarm on, floor conditions, patient destination/ reason for getting out of bed/ chair, feedback from patient. Background-risk factors circled and medications received in last 12 hours completed. Assessment of what happened and recommendations for preventative measures. Person Responsible: Medical Surg-ical Care Team and CNS Action: LEAF signage (acronym for Look, Enter, Assess, and Follow up) PPH designated symbol used to iden-tify patients with fall risk added to patient assignment board to heighten awareness of fall risk patients throughout the Medical Surgical Care Team. Introduced concept to our volunteer group to ensure their participation in fall prevention during time spent on units.	2/17/10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050636	A. BUILDING _____ B. WING _____	02/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMERADO HOSPITAL	15615 POMERADO ROAD, POWAY, CA 92064 SAN DIEGO 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
	Continued From page 6 Process. According to the policy, the next intervention for a patient pulling out lines or being aggressive would have been restraints. According to the administrative staff, while the policy directs staff to use restraints, the facility practice is to avoid the use of restraints. The policy delineated alternatives to be used prior to a sitter as the following; 1.) Asking patient family to sit with patient. 2.) Move patient closer to nursing station. 3.) Collaborate with physician to ensure patient is receiving appropriate medication for symptom management. 4,) Consider implementing restraints per Procedure 5.) If patient is at risk for falling, implement procedure for safety measures including tab alarm and bed alarm to warn of patient exiting bed. According to the physician progress note following the fall, dated 1/31/10 at 11:21 a.m., the patient fell, hit his head, sustained a bruise to the side of his head. The patient had become minimally responsive and lethargic following the fall. The physician had spoken with a neurosurgeon but given the patient's baseline dementia felt the patient had a poor prognosis. According to the note, the physician spoke with Patient A's son, who agreed with comfort/conservative management and a hospice evaluation was ordered. Patient A was placed on Hospice care with comfort measures only on 2/1/10 and discharged on 2/2/10 to an extended care facility on Hospice. Patient A expired on 2/4/10.		Continued From Page 5 Monitoring Process: Supervisors/ Relief Charge RNs review patient assignment board during shift hand-off. Person Responsible: Medical Surgi-cal Care Team Action: PEER Audits developed to monitor staff adherence to fall standards and share results with staff on an on-going basis to incl-ude Morse fall assessment, leaf signage in place, fall care plan initiated, bed exit alarms on, Tab alarms in place, call light place-ment, bed position, and patient diagnosis of dementia. Fall data graphs posted on units. Monitoring Process: Peer audits to be completed quarterly x4. Person Responsible: Eva Krall, CNS and Peggy Smith, staff fall preven-tion champion. Action: Decentralized nursing staff out of nurses' station to patient room areas for documentation with mobile computers to increase line of sight and reaction time to	3/1/10 3/8/2010

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050636	A. BUILDING _____ B. WING _____	02/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMERADO HOSPITAL	15615 POMERADO ROAD, POWAY, CA 92064 SAN DIEGO 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
	Continued From page 6 According to record review and interview, Patient A's plan of care was implemented on the day of admission when it was noted that he was at high risk to fall. The facility used the patient's son and on one occasion a volunteer to assist in the observation of Patient A. The facility moved the patient closer to the nursing station, and called the physician on several occasions for medication adjustments. Despite these interventions, documentation and interview revealed continued multiple attempts and occurrences of Patient A getting out of bed unassisted. The facility was unable to show either the implementation of restraints per their policy, or the implementation of a Patient Observation Assistant [POA], when alternative methods failed to prevent falls and provide for the safety of Patent A. The facility's failure to accelerate a plan of care related to a patient's high risk to fall is a deficiency that has 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). [FN1]What time?		Continued From Page 6 to patients with fall risk. Monitoring Process: Unit Supervisors and CNS rounding to reinforce "taking out to the patients". Person Responsible: Medical Surgical Care Team and Leadership Team. Action: Case study presentation (falls) presented at staff meeting emphasize fall prevention and interventions with staff participation. Person Responsible: Eva Krall, MedSurg CNS, and Jack Close, Gerontology CNS Action: Asked Sam Kovacevich, MST staff member to review current patient Tab alarms and perform literature review/availability of alternative Tab alarm system and bed/chair cushion alarm system. New Tab alarm identified, Adult Inpatient Director ordered for pilot. Outcomes: New Tab alarm ordered, but unable to use due to magnet attachment and potential	2/23/10 2/9/10 2/18/10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050636	A. BUILDING _____ B. WING _____	02/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POMERADO HOSPITAL	15615 POMERADO ROAD, POWAY, CA 92064 SAN DIEGO 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
			Continued From Page 7 interference with pacemakers. Bed/chair cushion alarm system ordered and introduced to staff. Staff education on current Tab alarm system performed. Person Responsible: Leadership Team/CNS Action: Presentation on fall prevention and "LEAF" designation to Environmental Services team and student volunteer coordinator. Person Responsible: Eva Krall, CNS	2/9-2/18 2010 2/24/10

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