CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF PUBLIC HEALTH

INMEDICAL CENTER SUMMARY STATEMENT OF DEPICENCES 200 WEST ARROR DRIVE MS 8949, SAN DIEGO, CA 92103-8976 SAN DIEGO COUNTY CALID		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP IDENTIFICATION 050025			(X2) MUL [*] A. BUILDII B. WING	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED 03/08/2011	
The following reflects the findings of the Department of Public Health during an inspection visit: The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00258021 - Substantiated Representing the Department of Public Health: Surveyor ID # 22479, 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. The hospital has a consolidated license of two campuses. Hospital has a consolidated license of an adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor. "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or	UNIVERSITY OF CALIFORNIA, SAN DIEGO			200 WEST ARBO			AN DIEGO	
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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. The hospital has a consolidated license of two campuses. Hospital A and Hospital B. 1279.1 (a) (b) (7) (d) Health and Safety Code An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor. "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or		Surveyor ID # 22479, HFEN The inspection was limited to the specific facility event investigated and does not represent the				re-educated and re-counse the ED Nurse Manager rega the incident, with writte confirmation of the verba warning placed in the emp	arding en al	3/14/11
The hospital has a consolidated license of two campuses. Hospital A and Hospital B. 1279.1 (a) (b) (7) (d) Health and Safety Code An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor. "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or will comply: Appropriate patient positioning Assessment/reassessment standards Standard of care of a pulmonary patient with emphasis on the subtle signs of hypoxia, maintaining patency of airway, and medications that may potentially alter airway.		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. The hospital has a consolidated license of two campuses. Hospital A and Hospital B.		te jeopardy" e licensee's juirements of		sites were re-educated o following via Power Poin presentations with a ret	on the at aurn	Power Points sent 3/2/11, 3/31/11 and 4/15/11
An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor. "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or *Standard of care of a pulmonary patient with emphasis on the subtle signs of hypoxia, maintaining patency of airway, and medications that may potentially alter airway.						will comply: • Appropriate patient	and, and	Educ- ation complete 5/13/11
impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or alter airway.		cause the death or				standards • Standard of care of	a	
Event ID: PI7Y11 12:46:95AM		impairment that subsithe major life activities of bodily function, if more than seven day	tantially limits one is of an individual the impairment is or is still prese	e or more of I, or the loss or loss lasts nt at the time	17	signs of hypoxia, maintaining paten airway, and medic that may potentia	cy of ations	
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(X6) DATE

UNIVERSITY OF CALIFORNIA, SAN DIEGO MEDICAL CENTER AUMANEY STATEMENT OF DEPOSITION OF DEPOSITION OF DEPOSITION OF COUNTY AND CONTINUE MS 8349, SAN DIEGO, CA 92193-8976 SAN DIEGO MEDICAL CENTER AUMANEY STATEMENT OF DEPOSITION OF DEPOSIT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
UNIVERSITY OF CALIFORNIA, SAN DIEGO MEDICAL CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR I.S.C. DENTIFYING INFORMATION) PROVIDER'S FLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CAPPOPER TAG		050025	В.	WING		03/08	3/2011
Continued From page 1 the loss of body part. 1279.1(c) Health and Safety Code Section, the facility shall inform the patient of the adverse event by the time the report is made. Title 22 Patient Rights Title 22 Patient Rights (a) Hospitals and medical staffs shall adopt a written policy on patients' rights. (b) A list of these patients' rights shall be posted in both Spanish and English in appropriate places within the hospital so that such rights shall be read by patients. This list shall include but not be limited to the patients' rights to: (c) Considerate and respectful care. (d) All hospital personnel shall observe these patient rights. The above regulation was NOT MET as evidenced by: Based on observation, interview, and record review Hospital A failed to provide considerate and respectful care to a patient (1) who was treated in the Emergency Department Nursing Director Emergency Department Selling Security Securit	UNIVERSITY OF CALIFORNIA, SAN	DIEGO 200 W	EST ARBOR DE			SAN DIEGO	
the loss of body part. 1279.1(c) Health and Safety Code Section, the facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made. Title 22 Patient Rights (a) Hospitals and medical staffs shall adopt a written policy on patients' rights. (b) A list of these patients' rights shall be posted in both Spanish and English in appropriate places within the hospital so that such rights shall be read by patients. This list shall include but not be limited to the patients' rights to: (2) Considerate and respectful care. (d) All hospital personnel shall observe these patient rights. The above regulation was NOT MET as evidenced by: Based on observation, interview, and record review Hospital A failed to provide considerate and respectful care to a patient (1) who was treated in the Emergency Department Nursing Director Responsible Persons: Emergency Department Nursing Director Emergency Department Nursing Director Emergency Department Nursing Director Emergency Department Nursing Director Emergency Department Nursing Director Emergency Department Nursing Director Emergency Department Nursing Director Emergency Department Nursing Director Emergency Department Nursing Director Emergency Department Nursing Director Emergency Department Nurse All Security Agents were provided training via a Power point presentation at monthly Security Services Staff meetings and with one-to-one education. The training included the proper positioning of individuals. (See Attachment 2D - Power Point training included the proper positioning of individuals. Eaglor All Security Agents were provided training via a Power point presentation at monthly Security Services Staff meetings and with one-to-one education. The training included the proper positioning of individuals. (See Attachment 2D - Power Point training of individuals. (See Attachment 2D - Power Point training of individuals. (See Attachment 2D - Power Point training of individuals. (See Attachm	PREFIX (EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PRI	EFIX (E	ACH CORRECTIVE ACTION SHOULD	BE CROSS-	COMPLETE
(d) All hospital personnel shall observe these patient rights. ED Nursing leadership will conduct 10 staff interviews per month to assess if staff can articulate existing standards of care for pulmonary patients. The above regulation was NOT MET as evidenced by: Based on observation, interview, and record review Hospital A failed to provide considerate and respectful care to a patient (1) who was treated in the Emergency Department (ED). As a result, Patient 1 suffered a cardio-respiratory arrest during ED Nursing leadership will 4/19/11 to 8/19/11 Ongoing if compliance not met The Hand Off Audit Tool will be used (See Attachment 2F). Immediate feedback and counseling will be provided as needed. Results of these reviews	the loss of body part. 1279.1(c) Health and facility shall inform responsible for the part that the time the report is multiple. Title 22 Patient Rights 70707 Patient Rights (a) Hospitals and written policy on patient written policy on patient both Spanish and within the hospital so by patients. This	the patient or the atient of the adverse ever ade. medical staffs shall ad ts' rights. tients' rights shall be posenglish in appropriate that such rights shall be list shall include but not the posenglish in appropriate that such rights shall be list shall include but not the posenglish in appropriate that such rights shall be list shall include but not the posenglish in appropriate that such rights shall be list shall include but not the posenglish in appropriate that such rights shall be list shall include but not the patients are the patients and the patients are the patients and the patients are the patie	party ent by dopt a sted in places e read	Resp Emer Dire Emer Mana Emer Nurs All prov poin Secu and The posi Atta trai shee	gency Department Nurctor gency Department Nurger gency Department Cli e Educator Security Agents were ided training via a t presentation at mority Services Staff with one-to-one educ training included th tioning of individual chment 2D - Power Po ning and 2E - sign- ets) consible Person:	Power onthly meetings ation. Lee proper cls. (See int off	Mtgs 3/18/11 and 4/15/11 Training complete by
Event ID:BI7X11 12/13/2011 11:46:25AM	(d) All hospital patient rights. The above regulation by: Based on observation Hospital A failed respectful care to a the Emergency Dep Patient 1 suffered a	was NOT MET as evident, interview, and record to provide considerate patient (1) who was treatment (ED). As a cardio-respiratory arrest from the ED.	review e and ated in result, during	ED M cond mont arti care The used Imme cour need will	fursing leadership will luct 10 staff interviols to assess if staff culate existing start for pulmonary paties. Hand Off Audit Tool (See Attachment 2F) ediate feedback and seeling will be provided. Results of these	ews per can dards of ents. will be ded as e reviews	4/19/11 to 8/19/11 Ongoing if comp- liance

TITLE

(X6) DATE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII		(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURY COMPLETE	25,74
		050025		B. WING		03/08	/2011
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRESS,	CITY, STATE,	ZIP CODE		
UNIVERS MEDICAL	ITY OF CALIFORNIA, SAN CENTER	DIEGO	200 WEST ARBO COUNTY	OR DRIVE M	IS 8949, SAN DIEGO, CA 92103-8976 S	SAN DIEGO	
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	Continued From page	2					
	Findings: 1. Patient 1 was action of the treatmulceration after sustainmouth according to department medical dot A review of Paties conducted on 1/6/11 nursing note written	ent of a hard palar ining a burn to the o the ED MD octor) notes. ent 1's medical at 4:00 P.M. Acc	record was		Department of Emergency (DEM) Physician and Nursi Leadership meetings and Council (QC). Responsible persons: Emergency Department Nur Director Emergency Department Nur Manager Emergency Department Ass Nurse Managers Emergency Department Cli	ng Quality ssing se	Monthly report to QC 5/25/11 to 9/28/11 and to DEM 5/10/11 to 9/20/11 Ongoing if comp-
	dated 10 and ti	med at 2:20 P.M. e initially and corted from ED	Patient 1 to sign		Nurse Educator Director of Regulatory A Plan of correction: A "Patient Discharge Pol		liance not met
	want to go home becau	regiver on 1/7/11 a that Patient 1 told the ED because s further stated that use she did not feel w	t 10:55 A.M. her that she he could not she did not vell.		Force" was established to a process to address path who refuse to leave the when medically cleared a discharged. The Task Formembership included: • Nursing Director for Coordination	co create cients hospital and orce	4/15/11
	On 1/14/11 an intended Technician (EDT 1) a after returning from ED to make a phone hospital security age the ED. Patient 1 NR Registered Nurse (EECRN told EDT 1 that in a cab to go hagents, the ECRN, at in the cab she went limited to the second to the second to the second technical second to the second technical second technic	at 4:45 P.M. EDT lunch, he went ou call. That's when ents escorting Patie was walking. The ECRN) was present the plan was to prome. When the end EDT 1 tried to p	1 stated that tside of the he saw two ent 1 out of ED Charge ent, as well. The two security ut Patient 1		• Associate Director Coordination • Director of Security Services • Nurse Manager for P Services • Director of Regulaty Affairs • Director of ED / Cr Care Services • Clinical Nurse Educy Emergency Departm	y sychiatry ory itical ator - ent	
Event ID	:BI7X11		12/13/2011	11:46	6:25AM	agemene	

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF PUBLIC HEALTH

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		050025		B. WING	-	03/08/2011	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF CALIFORNIA, SAN DIEGO MEDICAL CENTER			STREET ADDRESS, O 200 WEST ARBO COUNTY		ZIP CODE S 8949, SAN DIEGO, CA 92103-8976 \$	SAN DIEGO	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DI	BE CROSS-	(X5) COMPLETE DATE
	Continued From page ECRN decided to ta Patient 1 was then of bench and placed pro downward) on the s EDT 1 stated that this Patient 1 to be in give explained that by " was morbidly obese excess body fat has it may have an adve stated that Patient minutes until they tur established that she wa An interview was cor on 2/17/11 at 2:15 P that he was called to 2:00 P.M. When he ED, Patient 1 was ref Patient 1 said that s Security Agent 1 ner she did not want to 1 off the gurney and sh Security Agent 2 to outside the ED wher Agent 1 further stated member told the patie premises they were trespassing. That s patient by both of the Agent 1 then explain bench at the loop wa When the taxi cab a passenger door. Pa They were joined by El	ake Patient 1 out carried upside dow one (lying with the idewalk in front of its was not the best en her anatomy. Example of the idea of t	in toward a front or face the bench. position for DT 1 further int that she on in which extent that in). EDT 1 a couple of and it was a couple of and it was a couple of and it was a couple of a couple of and it was a couple of a couple of and it was a couple of a couple of a couple of a couple of and it was a couple of a couple		The Task Force updated M Center Policy (MCP) 301. Patient Admission and Di to include a process for patients who refuse to I facility after being med cleared and discharged. policy revisions include • The process to be for if a patient refuse leave for non-clime reasons; • The process to be for if a patient refuse leave for clinical reasons. (See Attachment 2G - Reto MCP 301.4) All Physicians were proveducation via a memo sememail regarding the revimant process for patients who to leave the facility after being medically cleared discharged. (See Attachment Education regarding the revisions to MCP 301.4 Padmission and Discharge, focuses on the process for patients who refuse to I facility after being medically aft	eave the ically The : collowed ses to nical	Revis- ions were approved by Nurse Exec- utive Comm- ittee 4/14/11 and Medical Staff Exec- utive Comm- ittee 04/15/11 E-mail sent 4/19/11
Event ID:	BI7X11		12/13/2011	11:46	25AM		

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

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(X6) DATE

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLI AND PLAN OF CORRECTION IDENTIFICATION N			***************************************	IPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		050025		A. BUILDIN B. WING	JG	03/08/2011	
NAME OF PRO	OVIDER OR SUPPLIER		STREET ADDRESS	, CITY, STATE,	ZIP CODE		
UNIVERSITY OF CALIFORNIA, SAN DIEGO MEDICAL CENTER		DIEGO	200 WEST ARBO COUNTY	OR DRIVE M	S 8949, SAN DIEGO, CA 92103-8976	SAN DIEGO	
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	successful in getting	Patient 1 into th	e taxi cab		provided to Emergency De	partment	Attest-
	The taxi cab driver d				Physicians, Attendings a	nd	ations received
	home if she could no	ot help herself. Se	curity Agent		Residents via email with	a	by
	1 recalled Patient 1 s	No. and the second seco			return email response at	testing	4/21/11
	but the words were of breath. Patient	#UMBACH _ GRANGER GERMANE GRAN			that they have read, und	erstand,	
	the taxi. The ECRN				and will comply with the		
	carried Patient 1 face				content. (See Attachmen	t 2I -	
	face down on the				email & Attachment 2J -	Memo)	
	About 5 minutes later, the ED Case Manarrived and suggested that they turn Patient 1 of When they did Patient 1's lips were observed to purple. Cardio-Pulmonary Resuscitation (Common was initiated. Patient 1 was then placed on a board, raised to a gurney and taken back in to ED. On 2/17/11 an interview was conducted with RN who was the ED discharge RN for Patient 10. RN 1 did not remember if Patient 1 her why she did not want to leave the However, RN 1 did state that she thought Patient 1 had significant lung problems. RN believed that Patient 1 had COPD (Chr. Obstructive Lung Disease). A review of Patient medical records from four previous hospitalizate.				Education regarding the revisions to MCP 301.4, including the process for patients who refuse to I facility after being medicleared and discharged with provided to Emergency De Nursing staff via either one-to-one education or Point presentation via ewith a return e-mail result attesting that they have understand, and will communicate the content. (See Attach Power Point Presentation Attachment 2K - ED comp Validated Tool).	eave the cically as partment a Power mail ponse read, ply with ment 2B, and	Email sent 4/15/11 Educ- ation complete by 5/13/11
at Hospital A verified that Patient 1 had diagnosed with COPD and obesity hypovent (inadequate ventilation).		poventilation		Education regarding the revisions to MCP 301.4 F Admission and Discharge,		Security Educat- ion complete	
	A security surveillance				focuses the process for		4/21/11
	area at the time of				who refuse to leave the		100 (5
	2/23/11 at 10:30 A.M. the details of the in				after being medically cl		
	EDT 1 and Security Ag		ed by bour		and discharged was provi		
Event ID:E	BI7X11		12/13/2011	11:46	:25AM		

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(X6) DATE

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM 050025		(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE SUR COMPLETE		
UNIVERSITY OF CALIFORNIA, SAN DIEGO			STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST ARBOR DRIVE MS 8949, SAN DIEGO, CA 92103-8976 SAN DIEGO COUNTY					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FUL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETE DATE	
	2/23/11 at 1:47 P.M. Security Agents, EDT out of the ED. Pat the bench at the loc Patient 1 resisted be stated that he made out of the taxi cab. Agent 1 carried Patie to the bench and plate on her stomach. EC called the ED Nurse EDNM arrived she as	conducted with the	nt that the Patient 1 50 yards to cab arrived b. ECRN Patient 1 nd Security (n) halfway he cement phone and When the Patient 1		all Security Agents via one-to-one training and all inpatient nursing le via e-mail for educating staff (See Attachment 2E sign-in sheets for Secur Agents and 2L - email se Nurse Leaders) Responsible person: Director of Risk Managem Associate Director Clini Services - Emergency Dep Director, Education Devel and Research.	eaders g nursing	E-mail sent to nursing leaders on 4/16/11 Education complete 5/13/11	
	she had no involvem called by the ECRN. area she saw two since ECRN. Patient 1 was stated that she was see Patient 1 lying the ED. After the infecent ECRN. The ECRN that the prone position obese person the potential for respiratory according to Patient was resuscitated, in through the mouth	ent with Patient 1 price. When she arrived a security agents, EDT as lying face down. In a little surprised and prone on the sideway ancident the EDNM specification was not a safe prone on the safe prone on the sideway and the EDNM specification was not a safe prone on the safe prone on the sideway and the EDNM specification was not a safe prone on the safe prone on the safe prone on the safe prone on the safe prone of the	stated that or to being at the loop 1, and the The EDNM d upset to alk outside oke to the being told position for ue to the Patient 1 of a tube for the		Monitoring: Audit to Include: Audits will be performed the Patients Refusing Day Monitoring Tool. Record be audited for appropriate documentation and complished with the revision to the of MCP 301.4 entitled, and Medically Cleared for Day Who Refuse to Leave the Hospital. To further enhance the approcess, the Audit Tool Patient's Discharged and to Leave was modified. To the Audit Tool increase audit criteria from five	ischarge ds will ate iance e section Patients ischarge audit for d Refused The edits ased the	Began 4/1/11 through 9/30/11 Ongoing if comp- liance not met Audit Tool revised by 6/14/11.	
Event ID	:BI7X11		12/13/2011	11:46	:25AM			
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	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050025			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		050025		B. WING		03/08/	/2011
NAME OF PRO	VIDER OR SUPPLIER		STREET ADDRESS, O	CITY, STATE,	ZIP CODE		
UNIVERSIT	TY OF CALIFORNIA, SAN CENTER	DIEGO	200 WEST ARBOI COUNTY	R DRIVE M	S 8949, SAN DIEGO, CA 92103-8976 \$	SAN DIEGO	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETE DATE
	Continued From page		t 1's 28 day		elements to eight. This		-0.00000111-0000.000
	intensive care unit (IC hospital stay she tracheostomy (surgic opening into the tra provide a passage discharged on device used to support. This deficiency has serious injury or deat constitutes an imm meaning of Health 1280.1(C). The facility failed to responsible for the p the time the report was This facility failed to described above that serious injury or deat constitutes an imm meaning of Health 1280.1(c).	required the insertal operation that chea with a tube for air). Paragraph of the trachea) in places caused or is likely that the patient, and safety Company and Safety Company of the adversarial of the adversarial of the deficiency caused, or is likely to the patient, and the deficiency of the patient, are lediate jeopardy	ertion of a creates an inserted to tient 1 was my stent (a c. by to cause and therefore within the ode section or the party se event by ency(ies) as y to cause, and therefore within the ode section or the party se event by		the auditor to better de a record is in compliance Medical Center Policy (M 301.4 Admission and Disc 2 of the additional auditionalude: • "Does the documentation identify a clinical non-clinical reason patient refused disc. • "Does documentation suppatient's discharge, for refusal to leave actions taken by nur other staff involved facilitating the pat discharge?" (See Attachment 2M - of Tool, Attachment 2N - net tool) In addition, the change Monitoring Tool provides separate sections for Mc compliance related to a refusing to leave post of for a clinical or non-cireason. The Audit Tool also inc. "Findings / Improvement Opportunities" section allows the auditor to graph specific feedback to a record review. Trends we reported in a monthly stage.	ce with MCP) charge. It items n clearly or why the harge?" opport the reason & sing or in ient's Id audit w audit to the s CP patient discharge linical ludes a which ive medical ill be	
Event ID:E	BI7X11		12/13/2011	11:46	:25AM		

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.

(X6) DATE

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF PUBLIC HEALTH

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		050025		B. WING		03/08	8/2011
UNIVERSITY OF CALIFORNIA, SAN DIEGO 200 W			REET ADDRESS, () WEST ARBO UNTY		ZIP CODE IS 8949, SAN DIEGO, CA 92103-8976 S	SAN DIEGO	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE DE	BE CROSS-	(X5) COMPLETE DATE
	hospital stay she tracheostomy (surgic opening into the traprovide a passage discharged on device used to support. This deficiency has serious injury or dear constitutes an immeaning of Health 1280.1(C). The facility failed to	CU). During Patient 1 required the insertio all operation that crechea with a tube insertion of the patient of the trachea) in place. Caused or is likely the to the patient, and hediate jeopardy with and Safety Code inform the patient or that item to the adverse the patient of the adverse that the control of the patient of the safety code inform the patient or that item to the insertion of the adverse that control operation is the safety code inform the patient or that item to the safety code inform the patient or the safety code in the s	on of a seates an serted to at 1 was stent (a to cause therefore thin the section the party		Identification of part to be audited: Security maintains a log they are summoned to asswith a patient refusing leave after being medical cleared and discharged. log will be utilized by Director of Risk Manager and/or designee to audit records per month for 4 Monitoring will also independently of patient complainments and feeling readischarge. To further streamline the process:	g when sist to ally The the ment t 20 months. clude a ints, o ady for	Began 4/1/11 through 9/30/11 Ongoing if comp- liance not met.
This facility failed to prevent the deficience described above that caused, or is likely to serious injury or death to the patient, and constitutes an immediate jeopardy with meaning of Health and Safety Code 1280.1(c).			cause, therefore hin the		• The Director of Patient Experience Service Excellence (PESE) was educated that the austral "patients who are distant and refuse to leave" include We Listen das both inpatient and Experience (ED) We Let The Director of Secur provide the Security patients who are distant refuse to leave, Risk Manager and the Director of PESE by of every month.	s dit for scharged is to ta for mergency istens. ity will Log for charged to the	Dates estab- lished 5/31/11
Event ID	:BI7X11		12/13/2011	11:46:	25AM		
ABORATO	RY DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTA	TIVE'S SIGNATU	IRE	TITLE		(X6) DATE

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF PUBLIC HEALTH

			R/CLIA MBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		050025		B. WING		03/08	3/2011
NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF CALIFORNIA, SAN DIEGO MEDICAL CENTER			STREET ADDRESS 200 WEST ARBO COUNTY		ZIP CODE IS 8949, SAN DIEGO, CA 92103-8976	SAN DIEGO	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY I SC IDENTIFYING INFORMAT	-ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETE DATE
f	Continued From page intensive care unit (III hospital stay she tracheostomy (surgic opening into the traprovide a passage discharged on device used to support. This deficiency has serious injury or deal constitutes an immeaning of Health 1280.1(C). The facility failed to responsible for the pthe time the report was. This facility failed to described above that serious injury or deal constitutes an immeaning of Health 1280.1(c).	CU). During Patien required the inse al operation that chea with a tube for air). Pat 0 with a tracheostor the trachea) in place caused or is likely that to the patient, and ediate jeopardy and Safety Co inform the patient of the advers made. prevent the deficie caused, or is likely to the patient, and ediate jeopardy	rtion of a creates an inserted to ient 1 was my stent (a y to cause and therefore within the de section or the party se event by event by event by event by to cause, d therefore within the		• The Director of PESE we cross-walk patient/venames from both inpatemergency Department complaints, "We Listed determine if there a additional cases to reviewed by the Risk. • The Director of PESE and Risk Manager determine if the patients and the patients and the patients are received in Risk Management from PESE. • The Risk Manager will a the Patients Refusion Discharge Monitoring using the above data 4th Wednesday of even Results of the audits were ported to the Department Emergency Medicine (DEM) Leadership (Nurses and Physicians) on a monthly and to Quality Council monthly basis Further act will be taken as necessary Director of Risk Manager Director of Security Second in the patients of the sudity Second in the patients of the audits were ported to the Department Emergency Medicine (DEM) Leadership (Nurses and Physicians) on a monthly and to Quality Council monthly basis Further act will be taken as necessary Director of Risk Manager Director of Security Second in the patients of Security Second in the pati	isitor tient and patient ens," to re be Manager. nd the ned the s the tient isten) a is to complete g Tool by the ry month. ill be ent of / basis (QC) on a ction ary.	Security log provided by 5th of every month We Listen data provided by 10th of every month Audit Tool complete by 4th Wed. of every month Monthly to To DEM 5/10/11 to 10/11/11 and to QC 5/25/11 to
					Director of Emergency De Director of Regulatory	epartment	10/26/11
Event ID:			12/13/2011		:25AM		
LABORATOR	RY DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESEN	TATIVE'S SIGNA	TURE	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

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		050025		B. WING		03/08/2011	
	IDER OR SUPPLIER OF CALIFORNIA, SAN ENTER	DIEGO	STREET ADDRESS, 0 200 WEST ARBOI COUNTY		ZIP CODE S 8949, SAN DIEGO, CA 92103-8976 S	SAN DIEGO	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE DI	BE CROSS- COMPLETE	
ir h tt cop d d d d T s c c m 1 T re tt d s c c m	continued From page intensive care unit (IC nospital stay she racheostomy (surgical pening into the trace provide a passage discharged on the continued of the passage of the continued of the con	CU). During Patien required the inset al operation that chea with a tube for air). Pat 0 with a tracheostor the trachea) in place caused or is likely in the patient of the adversimade. prevent the deficience caused, or is likely in to the patient, and additional contents of the adversimal caused, or is likely in to the patient, and ediate jeopardy	rtion of a creates an inserted to the creates an inserted to the creates and inserted to the creates and therefore within the description or the party see event by the cause, do therefore within the creates and the cre		The facility failed to it the patient or the party responsible for the patithe adverse event by the the report was made. Plan of Correction: In the future the facing will notify the patient within five days of identification of an acceptant and prior to report to the California Depart to the California Depart of Public Health (CDPF per Health and Safety section 1279.1(c)	ent of e time ility nt adverse porting artment	
Event ID:BI7	7X11		12/13/2011	11:46	:25AM		

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

TITLE

(X6) DATE