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
	050757	A. BUILDING _____ B. WING _____	03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alvarado Hospital Medical Center	**6655 Alvarado Rd, San Diego, CA 92120-5208 SAN DIEGO COUNTY**

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00298850 - Substantiated Representing the Department of Public Health: Surveyor ID # 21053, 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. 1280.1(a) (c) Health and Safety Code Section 1280(a) If a licensee of a health facility 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			

Event ID:C7SP11 9/13/2013 9:15:22AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Peggy Bailey TITLE CNO (X6) DATE 9/27/13

By signing this document, I am acknowledging receipt of the entire citation packet, *Page(s). 1 thru 9*

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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	licensure has caused, or is likely to cause serious injury or death to the patient. (d)This section shall apply only to incidents occurring on or after January 1, 2007. With respect to incidents occurring on or after January 1, 2009, the amount of the administrative penalties assessed under subdivision (a) shall be up to one hundred thousand dollars ($100,000) per violation. With respect to incidents occurring on or after January 1, 2009, the amount of the administrative penalties assessed under subdivision (a) shall be up to fifty thousand dollars ($50,000) for the first administrative penalty, up to seventy-five thousand dollars ($75,000) for the second subsequent administrative penalty, and up to one hundred thousand dollars ($100,000) for the third and every subsequent violation. An administrative penalty issued after three years from the date of the last issued immediate jeopardy violation shall be considered a first administrative penalty so long as the facility has not received additional immediate jeopardy violations and is found by the department to be in substantial compliance with all state and federal licensing laws and regulations. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section. 1279.1. (a) A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse			

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	event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law. (b) For purposes of this section, "adverse event" includes any of the following: (5) Environmental events, including the following: (D) A patient death associated with a fall while being cared for in a health facility. (c) The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made. A tag 001 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			

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	70213 (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. 70215 (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 hospital failed to ensure that a Registered Nurse (RN) implemented a nursing plan of care and the hospital's "Fall Reduction" policy and procedure. When RN 1 turned off the bed alarm for a high fall risk patient (1), the patient fell out of bed and hit her head. Patient 1 sustained a bleed into her brain tissue as a result of the fall and expired the next day. Findings: On 2/9/12 at 1:00 P.M., an investigation and record review was initiated at the hospital as a result of Patient 1's death following a fall. Patient 1 was admitted to the hospital on [redacted]12 with a chief complaint of frequent falls, per a History and Physical (H&P) dated [redacted]12. Per the H&P, the		70213(a) A. Nursing Policy 128 "Nursing Policy and Procedure" reviewed and nursing leadership re-educated B. CNO C. All nursing policies are indexed and reviewed and revised according to date. Presented to nursing leadership and Policy and Procedure Committee for review and revision. D. 4/30/12	2/17/12

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	patient had a history of heart failure, atrial fibrillation (abnormal heart beat), stroke, diabetes, cancer, and gait instability. According to the H&P, the patient sustained a fall at a skilled nursing facility the day prior to her admission, and hit her head. A CT scan (special X-ray) was performed upon her admission to the hospital, which was negative for any bleeding in her brain, per the H&P. Patient 1 was admitted to the hospital's telemetry unit. On 2/9/12 at 1:15 P.M. the Medical Surgical Nursing Director (MSND) and Chief Nursing Officer (CNO) were interviewed. The hospital's initial event "summary" report, dated [redacted]/12, was also reviewed with the MSND and the CNO. Per the MSND, on [redacted]/12, hospital staff heard a "thud" and found the patient on the floor. Patient 1 was on the telemetry unit and was being administered a medication called Heparin, which thins the blood and increases a patient's risk for bleeding. Per the hospital's initial event "summary" report, dated [redacted]12, after the patient's fall, a CT scan was performed followed by a C-spine series (X-rays of the cervical spine). During the C-spine series Patient 1 became unresponsive. The CT results were conclusive for a "subdural bleed" (Bleeding into the space between the Dura (the brain cover) and the brain itself). Patient 1's physician was notified and the patient was transferred to the Intensive Care Unit (ICU). Per the MSND, Patient 1 had a "DNR" (do not resuscitate) order and the family opted to not proceed with surgical intervention to stop the bleeding in her brain. Patient 1 sustained a bleed into her brain tissue as		70215(b) A. Ongoing assessment of fall risk on all patients • A process was implemented to ensure the Fall Risk measures were in compliance. • RN#1 was sent home for not following hospital policy. RN resigned 2/13/12. • Documentation and hourly rounding sheets were initiated. Staff inserviced immediately. Inservices continued for: RN's, CNA's, Lab, Imaging, Respiratory Therapy, Clinical Dieticians, Sleep Lab, Speech Therapy, Occupational Therapy, Physical Therapy and outpatient OR/SDS/PACU. • Implemented portable "Personal Alarm" safety device. • Added "Post Fall Assessment" into electronic record to include assessment of: vital signs, pain, range of motion, activity at time of fall, notifications. • Revised Rapid Response form to include more comprehensive assessment to include: frequent vital signs, neurological checks, extremity checks, O2 stats and pain scale. • Added "Neurological Assessment" into Post-Fall assessment • Launched a formal Falls Education for all clinical staff.	2/9/12 2/9/12 2/9/12 2/16/12 2/20/12 4/21/12 4/17/12 4/4/12

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	a result of the fall and expired the next day. Per the CT scan report dated [redacted]/12, Patient 1 had developed "an acute right subdural hematoma measuring up to 1.8 centimeters (cm.) in diameter. There was an 8 millimeter (mm.) right to left midline shift (a shift of the brain past its center line) with mass effect (effect of a growing mass) on the right lateral ventricle (a fluid filled open space in the brain)." On 2/9/12 the hospital's "Falls Reduction" policy and procedure, dated 5/08 was reviewed. Per the policy, fall "interventions will be planned, implemented, and documented according to each patient's risk level and individual needs. These will be documented on the interdisciplinary plan of care." Per the policy's "High Risk for Harm Screening Tool", if a patient was on a blood thinning medication, such as Heparin, the patient was considered a high risk for harm from falling. A review of Patient 1's fall risk assessment scores revealed that Registered Nurses (RNs) assessed her as being a "high risk" for falling, per the Morse Fall Scale Risk Screening Tool, with a score of 45 (high risk scale 45-125). According to the Patient Care Management Report (care plan, no date) pertaining to falls, Patient 1's bed alarm was always to be on. RN 1, who was Patient 1's primary nurse on the day of the fall, was unavailable for an interview as she had resigned her position at the hospital.		70215(b) continued B. CNO Nursing Department Directors C. • Continued hourly rounding by staff on all high risk patients-ongoing • Charge Nurse rounding and on-the-spot education-ongoing. • Review of all adverse reporting of falls to include record review on all falls-ongoing. Will be reported to Medical Quality Committee, Pharmacy and Therapeutics Committee, Patient Safety and Quality Council, Medical Executive Committee and Governing Board. D. 6/21/12 and ongoing	2/6/12 2/9/12 2/9/12

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	On 2/16/12 at 9:30 A.M. an interview was conducted with RN 2, who was one of the first responders to Patient 1's room after her fall. Per RN 2, he heard a loud "crashing" sound and that is what prompted him to go to the patient's room. RN 2 stated that he did not respond to the sound of a bed alarm going off. Per RN 2, Patient 1 was on the floor with a pool of blood (approximately 5-8 inches in diameter) beneath her head. Per RN 2, the patient was breathing, but not responsive and not opening her eyes. On 2/16/12 at 10:00 A.M., an interview was conducted with RN 3, another first responder to Patient 1's room after the fall. Per RN 3, she heard "something hit the ground" and she went to the patient's room. Per RN 3, Patient 1's bed was not alarming. Per RN 3, after the patient was turned onto her back she became responsive. On 2/16/12 at 10:15 A.M., an interview was conducted with the telemetry unit Charge Nurse, RN 4, on [redacted]12. According to RN 4, she was at the nurses' station, and heard a Certified Nursing Assistant call out for help from Patient 1's room. Per RN 4, Patient 1's room was across from the nursing station and when she went to the patient's room she did not hear a bed alarm going off. Per RN 4, RN 1 "volunteered" to her and RN 3, that she turned Patient 1's bed alarm off , because the patient wanted to sit on the edge of the bed. Per RN 4, the bed alarms are sensitive, and when a patient sat on the edge of the bed, the alarm would frequently go off. Per RN 4, RN 1 admitted after she turned the alarm off, she left Patient 1's room			

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	to attend to another patient. On 2/16/12 at 8:30 A.M., an interview was conducted with RN 10 (another emergency responder to Patient 1's room). Per RN 10, when she arrived to Patient 1's room, RN 1 was there. RN 10 asked "what happened?" Per RN 10, RN 1 replied " The last time I saw her (Patient 1) she was sitting on the edge of the bed. She must have got up and fallen." On 2/16/12 at 11:30 A.M., an interview was conducted with the CNO. The CNO acknowledged that RN 1 failed to implement Patient 1's fall plan of care when she turned off the bed alarm. The CNO acknowledged that, per the hospital's fall reduction policy and procedure, fall reduction interventions will be planned and implemented. RN 1 failed to implement the fall reduction policy and procedure and Patient 1's fall risk care plan. As a result, Patient 1 fell, hit her head, and subsequently developed a bleed in her brain and expired the next day. On 3/22/12 at 3:00 P.M. the hospital Administrator, the Chief Financial Officer, the Chief Nurse Officer, and the Chief of Staff were informed of the potential for an Administrative Penalty to be issued as a result of that violation. The facility's noncompliance with these requirements, jointly, separately or in any combination, has caused, or is likely to cause, serious injury or death to the patient, and therefore, constitutes an immediate jeopardy within the			

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	meaning of Health and Safety Code Section 1280.1. 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).			