California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA050000014	A. BUILDING: _____ B. WING _____	C 08/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOSPITAL SAN BUEI	147 N BRENT ST VENTURA, CA 93003

(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
E 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident/Complaint. Entity Reported Incident No. 431439 and Complaint No. 431346 The investigation was limited to the specific complaint/self-reported event investigated and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: 32661 and 35399 (Trainee). Health & Safety Code Section 1279.1 (a) (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 event has been detected, or, if that event is an ongoing urgent or emergent thread to the welfare, health, or safety of patient, 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. Health & Safety Code, Section 1279.1 (b) (5) (D) (b) For purposes of this section, "adverse event" includes any of the following: (5) Environment events including the following: (D) A patient death associated with a fall while	E 000	Hospital leaders, including Chief Operating Officer, Chief Nursing Officer, Vice President, Quality, Director, Patient Safety, Director, Diagnostic Imaging, and Manager, Emergency Services met to identify root causes of event and implement immediate corrective actions: 1. The "Fall Prevention" policy was designed to address the process for inpatients. The Emergency Department (ED) policy, "Emergency Nursing Assessment" last review 3/22/2012 states under "Fall Risk Screening" that "all patients presenting to the Emergency Department for treatment of illness or injury are considered to be at risk for falls and universal safety precautions will be in effect. Special considerations for age and cognitive judgment will be assessed". Action taken: Implemented the use of the yellow arm band to identify patients at high risk of fall to facilitate staff awareness of need for prevention strategies in the ED. ED staff was educated by ED Nurse Educator via Staff Huddles, Education packets distributed personally and by email with read receipt to ensure 100% of staff was reached. Random audits were conducted by the Manager, ED to monitor implementation and to reinforce practice.	2/13/15 2/13/15 3/4/15 - 4/30/15

8/29/16 Accepted KR Chavez

2016 AUG 29 AM 10:39
VENTURA DISTRICT OFFICE

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lee Mott — TITLE: Vice President, Quality — (X6) DATE: 8-26-16

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E 000	Continued From page 1 being cared for in a health facility. Health and Safety Code Section 1279.1 (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." 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. 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.	E 000	2. The Patient Care Tech who is responsible for attending to patients awaiting imaging studies was out sick and no back-up staff was available or secured. Action taken: 2 additional positions were approved for recruitment to allow for increased coverage of this position. Schedule updated to provide coverage of this position to ensure patient observation and safety.	2/13/15
			3. ED Staff were re-educated on the requirement for hand-off report from primary nurse to receiving tech before transporting patients out of the department for tests and diagnostic procedures. Implemented the use of the yellow fall risk arm band to identify	2/13/15
E 294	T22 DIV5 CH1 ART3-70215(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. This Statute is not met as evidenced by: Based on observation, interview and record review the facility failed to implement policies and procedures related to a plan of care, fall preventions, and communication between caregivers for Patient A, who was a patient with a high risk for falls. As a result, Patient A, who had a history of falls and was on lifelong Coumadin anticoagulation therapy (a class of drugs that work to prevent blood clotting by thinning the blood) was left unattended in the radiology hallway, fell from the gurney, hit his head and sustained a skull fracture with bleeding in the	E 294	patients at high risk of fall to facilitate staff awareness of need for prevention strategies in the ED. ED staff was educated by ED Nurse Educator via Staff Huddles, Education packets distributed personally and by email with read receipt to ensure 100% of staff was reached. 4. Nursing Task Force convened to review and revise the "Fall Prevention" Policy to reflect current practice and needs of all patient care areas within the hospital. Initial revisions included deletion of "Falling Star" magnet, Chart sticker, bed alarm use changed to "as indicated". The Task Force was expanded to include staff from all patient care areas within CMH and OVCH. The policy was further enhanced to include screening criteria and fall prevention interventions. The yellow fall risk band was standardized as the primary alert for patients at high risk of fall throughout the hospital departments. Additionally, yellow gowns were implemented as a secondary high-risk fall indicator for the inpatient areas, with the exception of maternal/child health.	7/6/15 7/29/15 11/1/15

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E 294	Continued From page 2 brain. Patient A's condition deteriorated, resulting in the patient's death. According to Patient A's Certificate of Death dated 2/20/2015, the cause of Patient A's death on 2/12/2015 was "Blunt Force Injury of Head and Complications of Intracranial Hemorrhages" (bleeding in the brain). Findings: A review of Patient A's medical record was conducted on 3/5/15. According to the medical record, Patient A was transferred to the facility Emergency Department (ED) from a skilled nursing facility on 2/11/15 with complaint of a right buttock cellulitis/possible abscess (wound infection). According to the history and physical dated 2/11/15 at 5:55 p.m., Patient A was awake, alert and oriented X 3, with history of Pulmonary Embolism (PE-a condition in which one or more arteries in the lungs become blocked by a blood clot) and Deep Vein Thrombosis (DVT- a blood clot in a deep vein), for which he was on lifelong Coumadin anticoagulation therapy. Upon arrival to the ED on 2/11/15 at 2:54 p.m., RN 1 assessed Patient A to be at high risk for falls. RN 1 assigned a Fall Risk Score of "65" to Patient A. Review of the facility's policy and procedure entitled: "Fall Prevention," dated 2/20/14, indicated the following: "Patient will be assessed for fall risk utilizing the Morse Fall Risk Scale as a best practice assessment to determine the patient's potential for falling...as an indicator of the need for implementation of fall prevention strategies." The Morse Fall Risk Assessment Scale consists of six criteria for which the patient will be assessed to determine the risk level for fall. The six criteria are as follows: (1) History of fall, (2) Secondary diagnosis, (3) Ambulatory aid, (4) Intravenous	E 294	5. Emergency Department Picis EMR was revised to include Fall Risk assessment indicators, fall risk armband, high-risk interventions and change in assessment scoring for high risk diagnosis/recent fall event. 6. Nursing leadership and key clinical staff were educated on the policy changes and fall prevention best practices. An education program outlining the new Fall Prevention Policy and processes was assigned to all clinical staff. 1683 staff have completed the training with passing score. 7. Revised training on Fall Prevention policy and hourly rounding for fall prevention focus was implemented for general orientation. 8. Fall Prevention revised policy interventions; Universal and High-risk Fall interventions, were reviewed with clinical staff on one to one basis at the Patient Safety Fair. A total of 328 RNs and Nurse Techs received this education. 9. Ongoing patient fall prevention education is provided in the annual staff education training (Marathon) for 2015 and 2016.	9/5/15 8/4/15 - 8/12/15 9/1/15 3/4/16 8/11/15, 8/15/16

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E 294	Continued From page 3 (IV) or Saline lock, (5) Gait, transfer ability, (6) Mental status. These criteria are reviewed with patient, and a number of points are assigned for each criteria that applies to a particular patient and the points are added to calculate the score number in order to determine the risk level for falls. Furthermore, the policy also indicated: "Potential contributing factors that affect fall risk are also assessed and evaluated in conjunction with the Morse Fall Risk Score. Potential contributing factors include Polypharmacy (use of four or more medications by a patient, aged over 65 years), and Anticoagulant therapy." During an interview with RN 1 on 3/3/15 at 2:29 p.m., she stated she performed a Fall Risk Assessment on Patient A. He was assigned 25 points for history of falls, 20 points for dizziness/vertigo/polypharmacy, and 20 points for impaired mobility/generalized weakness totaling to 65 points, thus making Patient A at high risk for falls. The Morse Fall Risk Assessment tool, dated 2/20/14, as used by the facility, directs nurses completing the assessment, as follows: "Fall Risk Score greater than or equal to 51-Patient is at high risk for fall, initiate fall precautions for high risk score greater than 51." The facility policy entitled, "Fall Prevention," (Last revised 02/20/2014), indicated the interventions to be completed and documented include: 1.Yellow Arm Band placed on patient; 2. Falling Star Magnet placed on hallway doorframe; 3. Fall Prevention Sticker affixed to the front of the patient chart; 4. Bed alarm on; 5. Fall Risk, Fall Prevention is to be addressed in the nursing care plan. Furthermore, according to the facility's policy and procedure entitled, "Fall Prevention," dated 2/20/14, in the section of the policy entitled, "Fall Prevention Interventions for Identified at	E 294	Person Responsible for implementation: Director, Patient Safety & Clinical Risk Monitoring Plan: Auditing of the documentation forms for the patient hourly rounding, and bed alarm/ equipment proper functioning, are completed every shift by the charge nurse on the medical/ surgical units. Ongoing monitoring of staff compliance, RN and nurse tech, are completed by the nursing manager on a monthly basis. The nurse manager completes individual coaching/corrective actions for all RN/nurse tech staff who fail to complete less than 80% of the shift documentation for hourly rounding/ equipment functioning fall prevention initiatives.	11/1/15
			Ongoing monitoring of Fall prevention initiatives, and "Ticket to Ride" functioning will occur during the, "Patient Safety Rounding for Zero Preventable Harm" process effective 9/15/16. Results of the patient safety rounding process will be reported on a quarterly basis to the Patient Safety Council, Clinical Operations, and Board Quality effective 1/1/17.	9/15/16

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E 294	Continued From page 4 Risk patients" the following indicated: "Interventions to be completed and documented by a license nurse should be upon admission ...and as needed." A review of Patient A's clinical record on 3/9/15, at 9:45 a.m. revealed a document entitled, "Orders (General Medical Admission)", dated 2/11/15 at 5:54 p.m. These "Orders," indicated Patient A had been admitted to the hospital and considered an "Inpatient." During an interview with the Patient Safety/Clinical Risk director on 3/2/15 at 1 p.m., she stated that the hospitalist (a dedicated in-patient physician who works exclusively in a hospital) had written admission orders and the patient had been assigned as an inpatient but waiting for a bed to be cleaned on an inpatient unit. During a telephone interview on 3/3/15, at 2:29 p.m., RN 1 indicated interventions were not implemented for Patient A because there was no policy or processes indicating what interventions should be used in the ED. RN 1 shared "We do not have a set protocol or interventions here in the ED for high fall risk patients." RN 1 indicated "Universal fall precautions," are utilized in the ED, which according to RN 1, consist of side rails up and bed in low position. Patient A was transferred from the Annex (observation area in the ED) to the larger ED where RN 2 assumed care of the patient. During an interview with RN 2 on 3/2/15 at 3:45 p.m., RN 2 shared she was not aware Patient A was at a high risk for falls. RN 2 stated she used "Universal Precautions," which are used for all patients. RN 2 further stated, "There aren't any specific fall interventions or processes in the ED for high fall risk patients like in the hospital." She	E 294	1. ED Staff were re-educated on the requirement for hand-off report from primary nurse to receiving tech before transporting patients out of the department for tests and diagnostic procedures. Implemented the use of the yellow arm band to identify patients at high risk of fall to facilitate staff awareness of need for prevention strategies in the ED, Diagnostic Imaging and by transport. ED staff was educated by ED Nurse Educator via Staff Huddles, Education packets distributed personally and by email with read receipt to ensure 100% of staff was reached. 2. Transporters-Meeting of the transporters was conducted by the Manager, Nursing Resources, to review their role in fall prevention, specifically the meaning of the yellow arm band, measures they would take when transporting a patient with a yellow arm band, including to not leave patient unattended.	2/13/15 7/28/15

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E 294	Continued From page 5 reiterated ED staff use "Universal Precautions" and stated that these consist of side rails up and bed in low position. During an interview on 3/3/15 at 3:02 p.m., with the hospital transporter (HT) who transferred Patient A to ultrasound, he stated no care givers assigned to Patient A on 2/11/15 ever communicated that the patient was at high risk for falls. A review on 3/9/15 at 9:35 a.m., of facility policy and procedure entitled, "Communication Among Caregivers," (Last revised 2/2013), revealed the following: "SBAR (a hand-off communication format) should be used to communicate relevant information in order to ensure patient safety during transfers from one caregiver to another or from one department to another." Per the policy, the acronym "SBAR" means "Situation-Background-Assessment-Recommend ation," a standardized process of passing accurate and relevant patient-specific information. According to the policy, "Hand off communication is when information is transferred, along with authority and responsibility between caregivers or between departments or between health care disciplines." On 3/3/15, at 2:29 p.m., RN 1 was questioned about the communication of fall risk assessment to other staff. RN 1 stated, "Fall risk assessments are not communicated to other ED staff or rarely communicated. To be honest, this does not happen in this ED." Then she was questioned regarding the method of communication among caregivers. RN 1 responded: "There isn't a specific method of communication here in the ED. One just relates information verbally if we don't forget." She was further questioned about her	E 294	3. Current process for communicating fall risk for other departments for inpatients: A. Once patient is assessed within the inpatient electronic health record as being at high risk for falls, this message is automatically included on all order requisitions to Diagnostic Imaging, Physiology, Rehab, Lab. This process is not in place for ED patients as they are on a different electronic health record. B. Patient risk factors are input into the Teletracking system by the Charge RN and Unit Secretary which is present on all inpatient areas, ED and is used to communicate alerts to transporters via phone. The method and purpose for input of this information into the Teletracking system was reviewed with Nursing Leadership by the Manager, Nursing Resources. 4. Multidisciplinary Task Force met and developed a "Ticket to Ride" hand-off process for patients transported without primary LN in attendance. New process was pilot tested prior to full roll out. Nursing leadership and key staff were educated on the policy changes and fall prevention best practices. All clinical and transport staff assigned to complete an education program outlining the new Fall Prevention Policy and hand off processes. Revised Training on "Ticket to Ride" (TTR) was implemented for general orientation and included in new hire orientation, and Directors/ Manager clinical leadership team. 5. The "Transport of Patients" policy was revised to include use of "Ticket to Ride" as a communication tool between licensed staff, the transporter and be destination staff	8/4/15, 8/6/15, 8/12/15 7/28/15 9/1/15 8/4/15, 8/6/15, 8/12/15 10/1/15 8/1/15 7/7/16

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E 294	Continued From page 6 familiarity with the SBAR hand-off communication form. RN 1 responded: "No, we don't do that here in the ED. This is only for when we transfer the patient to the hospital bed." She was asked if the SBAR format would be used when a transporter is taking patients to other departments, RN 1 responded "No, not really." On 3/2/15 at 3:45 p.m., RN 2 was interviewed and questioned as to whether she had reported to the hospital transporter (HT) any special needs Patient A had. RN 2 stated that usually ED nurses do not give any type of report to transporters when the transporters take ED patients to tests or other departments. RN 2 responded: "There isn't any official hand-off in place to use when transporting patients to a test." On 3/3/15, at 3:05 p.m., the HT was interviewed and was asked if he received any report regarding Patient A being at risk for falls. HT responded, "I never get any type of report from the ED staff about patient's condition or needs." HT was questioned about the SBAR communication tool. HT responded: "I don't know what that is. I might have heard of it but I have never used it." On 3/2/15, at 3:28 p.m., the ultrasound technologist (UT) was interviewed and was asked if she knew Patient A was at risk for falls. The UT stated she would not have known the patient was at risk for falls since she did not get any report from RN 2 or HT. The UT responded: "The ED nurses and transporters never tell me anything about the patients. Transporters just let me know the patient is here, that's all." According to an interview with RN 2, on 3/2/15 at 3:45 p.m., she shared that on 2/11/15 Patient A	E 294	6. Ongoing random review of the TTR process/form completion was conducted by the nursing leadership of the medical/surgical units, ED and by the Dir. Patient Safety. It was identified that a revision of the ED fall assessment during the triage process and TTR form was needed. A task force, led by the Director, ED, completed the redesign triage process, fall risk arm band placement, and created a TTR form in the EMR. Training of the new process for the ED staff and transporters is currently being conducted. Go live of the new process is scheduled for 9/5/16. The effectiveness of the new electronic TTR form will be assessed by monitoring conducted by the Director, Emergency Services. The paper TTR form used in non-ED units is being evaluated for revision by the nursing leadership team. Revised TTR form/process is scheduled for implementation in 9/16. The current TTR forms remain in effect. The effectiveness of the revised Ticket to Ride form will be assessed by monitoring conducted by the Director, Med-Surg Nursing. Person Responsible for implementation: Director, Patient Safety & Clinical Risk Ongoing monitoring of Fall prevention initiatives, and "Ticket to Ride" functioning will occur during the, "Patient Safety Rounding for Zero Preventable Harm" process effective 9/15/16. Results of the patient safety rounding process will be reported on a quarterly basis to the Patient Safety Council, Clinical Operations, and Board Quality effective 1/1/17.	1/1/16 - 6/1/16 8/30/16 9/15/16

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E 294	Continued From page 7 was anxious and had requested Ativan (medication used for anxiety with drowsiness as a common side effect) which she gave intravenously. A review of Patient A's Doctor's Orders, dated 2/11/15 at 6:55 p.m., Medication Administration Summary, dated 2/11/15 at 6:55 pm., and Medication Discharge Summary Report, dated 2/11/15 at 6:55 p.m., indicated Patient A was administered 0.5 mg of Ativan at 7 p.m. A review of "Patient Order Summary", dated 2/21/15, indicated an ultrasound (an imaging method that uses high-frequency sound waves to produce images of structures within the body) of the right buttock was ordered for Patient A by the ED doctor at 5:56 p.m. According to an interview on 3/2/15 at 1 p.m., with the Patient Safety/Clinical Risk director, she stated that around 7:40 p.m., on 2/11/15, the HT took Patient A to the ultrasound department for the ultrasound. During the interview with the HT on 3/3/15 at 3:05 p.m., he stated that he approached RN 2 (the nurse caring for Patient A in the ED) to ask if he could take the patient to ultrasound. According to the HT, this conversation with RN 2 took place on 2/11/15 at approximately 7:37 p.m. RN 2 indicated approval to take Patient A to ultrasound. HT indicated that RN 2 did not communicate any fall risk concerning Patient A to the HT. The HT stated when he wheeled Patient A over to the ultrasound hallway at around 7:40 p.m., Patient A was laying horizontally on the gurney with the gurney's side rails up. HT recalled the patient being "sleepy" and "drowsy." According to HT, transporters do not stay with the patients. Their job is only to transport patients from one place to another within the hospital. If the patients need someone to stay with them, it would have to be the patient's "nurse."	E 294		

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E 294	Continued From page 8 HT further advised that when they arrived in the ultrasound department hallway, the HT verbally notified the UT that the patient was in the hallway. HT was leaving for his next transport job when Patient A stated he needed to urinate. The HT grabbed a urinal, handed it to Patient A and instructed him to hang the urinal on the side of the gurney when he finished. Patient A grabbed the urinal from HT, replied "okay," and was left alone in the hallway. The HT stated he didn't know how long Patient A was left alone in the hallway before the patient fell off the gurney, because the HT had left the area to do other transporting jobs. In an interview on 3/2/15 at 3:28 p.m., the UT stated the HT told her Patient A was in the hallway on 2/11/15 at approximately 7:42 p.m. According to the UT, she received no report or communication from anyone in ED or from the HT that Patient A was a high risk for falls. At approximately 7:42 p.m., she was inside the ultrasound room with another patient. She came out of the ultrasound room to see Patient A in the hallway then she went back to the ultrasound room to complete the ultrasound. At approximately 7:55 p.m., the UT heard a loud thud in the hallway and found Patient A on the floor in a puddle of urine. The UT stated she noticed the patient was away from the gurney and stated, "The patient must have tried to walk away from the gurney and fell." There were no witnesses as to how Patient A fell off the gurney. The UT further advised that when the loud thud was heard, staff came out of their departments saw Patient A on the floor and called the rapid response team (RRT). The RRT-(team of health care providers that respond to hospitalized patients with early signs of clinical deterioration)	E 294		

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E 294	Continued From page 9 responded to the patient's fall. According to a review of Patient A's medical records, Patient A sustained head injuries as a result of the fall from the gurney. Patient A sustained a left-frontal subdural skull fracture and subarachnoid bleed (bleeding into subarachnoid space of the brain) as indicated on CT (computerized tomography (CT)) scan results dated 2/11/15 at 9:31 p.m. (test that uses a special X-ray machine to take pictures of a patient's brain, skull, and blood vessels in the head). A neurosurgical consult was requested for Patient A following Patient A's fall. The medical record revealed the neurosurgical consult and examination of Patient A took place on 2/12/15 at 8:07 a.m. MD 2, a neurosurgeon, was interviewed on 3/2/15 at 4:55 p.m., MD2 stated, "The patient (Patient A) was still too anticoagulated; the bleeding was everywhere in the head; there wasn't any surgical interventions for this type of bleeding." A review of MD 2's notes dated 2/12/15, at 8:07 a.m., indicated he recommended admission to the Intensive Care Unit (ICU) for Patient A to monitor an increased INR (international normalized ratio-a test which measures the time it takes for the blood to clot) until treatment for reversal of INR was completed. A review of Patient A's medical records indicated that on 2/12/15, at 8:23 a.m., a head CT was repeated and indicated a significant progression of the brain bleeding, per MD 2's consultation report. According to the discharge summary of the facility physician (MD1) dated 2/13/15, at 08:25 a.m., it indicated that Patient A would not have benefited from any neurosurgical intervention, that Patient A's mental status	E 294		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA050000014	A. BUILDING: _____ B. WING _____	C 08/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 294	Continued From page 10 continued to deteriorate and that Patient A passed away on 2/12/2015 at 10:05 p.m. The facility failed to ensure that staff planned and delivered a safe plan of care for Patient A. Specifically, the facility failed to perform a communication hand-off to caregivers responsible for administering care and treatment to Patient A, pursuant to facility policy and procedure, prior to transporting Patient A to the ultrasound department from the emergency department. The facility further failed to communicate to caregivers responsible for administering care and treatment for Patient A that Patient A was at high risk for falls. Consequently, Patient A was transported to the ultrasound hallway, left alone and unattended without appropriate fall interventions being implemented, pursuant to facility policy and procedure. The facility's failure to first implement fall interventions, pursuant to the facility's policies and procedures, for a patient who was at high risk for falls, and the facility's failure to communicate between caregivers and departments regarding the status and risk for falls are deficiencies that have caused, or are likely to cause, serious injury or death to the patient.	E 294		