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
	050366	A. BUILDING _____ B. WING _____	06/12/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARK TWAIN ST. JOSEPH'S HOSPITAL (4RH)	768 MOUNTAIN RANCH ROAD, SAN ANDREAS, CA 95249 CALAVERAS 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 the investigation of Complaint # CA 00139414. Representing the Department: [redacted] HFEN #1700 The Inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. T22 DIV5 CH1 ART3-70213 - Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. This RULE: Is not met as evidenced by: Based on staff interview and clinical record review the facility failed to ensure policies and procedures (P&P) were implemented for patient care related to fall prevention and restraints. The P&P Fall Prevention (11/10/03) and the Use of Physical Restraints P&P (4/16/07) were not followed for Patient 1 who was assessed at high risk for falls on admission. The Patient Care Plan did not indicate interventions such as monitoring the patient closely, or placing bed in low position as per P&P. Staff used restraints without clinical justification for use and without appropriate assessments. On 1/20/08 at 12:15 p.m. Patient 1 fell out of bed and sustained displaced left femur fracture. Patient 1 expired on 1/23/08. The facility's failures resulted in harm to Patient 1, constituting an Immediate Jeopardy (IJ). The IJ was		We have undertaken the following corrective actions for the patients identified to have been affected by this issue: • A review and revision of the hospital's Fall Prevention and Management Policy was initially completed in October, 2008 to identify additional methods of identification of Fall Risk patients. We further completed a revision of this policy on 6/22/09 to include the use of Morse Fall Risk Assessment Scale. Staff was educated on the revised methods of identification of Fall Risk patients, including the implementation of the use of a yellow arm band, yellow blanket, yellow non-skid slippers and a large 8 ½" by 11" sign at the head of the bed to indicate that a patient is a fall risk. In-service of staff was undertaken in several stages and completed for all patient care staff via competency by 7/29/09. • A review and revision of the hospital's Fall Prevention and Management Policy was done to insure that the "bed alarms" are listed as one of	7/29/09 7/29/09

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: President | (X6) DATE: 9-3-09

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	Continued From page 1 called on 6/12/09 at 2:15 p.m. with the hospital's administrative and risk management staff. On 6/15/09 the facility presented written acceptable plan of correction that included revisions to P&Ps and staff training. The IJ was lifted on 6/24/09 at 3:55 p.m. with the administrative and risk management staff present after the facility presented and implemented the plan of correction, confirmed during an on-site visit. Findings: Review of the P&P for Fall Prevention (11/10/03) indicated patients' fall risk potential will be assessed on admission and every shift. Fall Prevention Protocol will be initiated at any time indicated by the Admission Assessment or by the 24 Hour Flow Sheet guidelines. The procedure section directed to refer to Fall Prevention Patient Care Plan. The nurses' notes should include documentation that Fall Prevention protocol was in effect and of "patient's mentation, physical condition, behavior and any changes of the same." The Patient Care Plan For Patients With Fall Prevention indicated interventions should include monitoring patients closely, place beds in low position, side rails must be up at all times, use restraint devices only if absolutely necessary (obtain order from physician) and utilize other measures to monitor patient such as bed check device, family member at bedside, bed rail alarm. The P&P Use of Physical Restraints (4/16/07) indicated (section 2.1) the use of restraints will be		**Continued From Page 1** the methods of fall risk precautions. In-service of staff on the use of the bed alarms was undertaken in several stages and completed for all patient care staff via competency by 7/29/09. • A review and revision of the hospital's Fall Prevention and Management policy on re-assessment expectations and hospital's patient fall notification process was completed by February 2008. In-service of staff was undertaken in several stages and completed for all patient care staff via competency was by 7/29/09. • A review and revision of the hospital's Fall Prevention and Management Policy on the activities to be undertaken by the supervisory staff in the event of a patient fall was completed by February 2008. A Supervisor/Management Fall Assessment worksheet was devised to be used by the House Supervisor, Charge Nurse or Department Manager in the event of a	7/29/09 3/26/09

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	Continued From page 2 done in a manner that protects the patient's health and safety and preserves his/her dignity, rights and well being. Restraint use will be limited to actual actions (Acute Medical/Surgical Restraints) or behaviors (Behavioral Restraints) that could cause harm to self or others (section 2.3). Acute Medical Restraints will be only used if needed in attaining or maintaining patients' practicable level of well being if less restrictive interventions have been ineffective and if the patient is at risk for interruption of medical therapeutic interventions. Physician will see and evaluate the patient within 24 hours of initiation of restraints (section 2.7.4). The patient will be observed every 15 minutes with restraint release every 2 hours. Physical restraints included vest and bottom side rails (section 4.2). Section 6.1 indicated that the use of restraint is limited to those situations for which there is adequate and appropriate clinical justification as well as proof that the use of alternatives poses more risk than restraint and all alternatives have been considered and attempted as appropriate. Section 7.1.2 indicated that the use of restraint occur only after all non-physical restraint alternatives to such use have been considered and attempted as appropriate. Such alternatives include, but are not limited to; increased observations and monitoring and use of a sitter. Sections 13.0- 13.1.3 for assessments indicated each patient will receive a comprehensive assessment prior to the use of any restraint device. All appropriate restraint alternatives will be		Continued from Page 2 patient fall. In-service of the appropriate staff was completed via acknowledgement by 03/26/09. • As part of the review and revision of the hospital's Fall Prevention and Management Policy, a Sitter Algorithm was devised to aid the staff in determining the need for sitter for appropriate fall risk patients. In-service of staff was undertaken in several stages and completed for all patient care staff via competency by 7/29/09. • Concurrent monitoring of all medium or high fall risk patients is being conducted using the following criteria: completion of Fall Risk Assessment on every shift; Implementation of fall identification strategies for every appropriate patient; use of the bed alarms for all high fall risk patients. Concurrent monitoring will be conducted for the next three months from 7/22/09, or until	7/29/09 7/22/09

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	Continued From page 3 evaluated for use and all appropriate alternatives will be attempted and documented. The comprehensive assessment of the patient must determine that the risks associated with the use of the restraint are outweighed by the risk of not using it. Section 14, orders for restraints, showed only a physician or a licensed practitioner may order restraint and standing orders are not acceptable. The order will include type of restraint, specific reason and circumstances for its use, duration of application and plan for progressive removal. Anew order is needed if restraints are removed and then replaced due to a change in the patient's condition. Continued use of restraint beyond the first 24 hours will be authorized by face to face assessment and written order clinically justifying the continued use of restraint. Section 15 indicated that after restraints are applied an immediate assessment will be completed to ensure that restraints were properly and safely applied. The assessment will be documented and include proper application of restraints, the patient's response, and if negative, the changes that were made. Section 19 for documentation indicated patient medical record for each episode of restraint will include the reevaluations of the patient by the RN and/or physician. Plan of Care documentation should reflect outcome oriented goal related to restraint use, description of interventions, discontinuance of the restraints and care plan update after restraint intervention is discontinued.		Continued from Page 3 compliance goal of 100% for the listed criteria is achieved. • A review of the hospital's Use of Physical Restraints Policy was completed on 6/15/09. All patient care staff was re-educated via competency on treating "4-side rails up" as restraints, the use of Sitter Algorithm, and the use of and documentation of implementation of alternatives to restraints by 6/24/09. • We revised the Physician Order for Acute Medical/Surgical Restraints from to include "4 side rails" in the Restraint Type category. We have in-serviced our physicians via memo distribution on 6/22/09. • We revised and updated the following hospital-use forms to include all appropriate information for Fall Prevention and Restraint Management: o Interdisciplinary Plan of Care by removing the "rails up x4" as a fall	6/15/09 6/24/09 6/22/09 6/22/09

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	Continued From page 4 The medical record review on 5/21/08 with the facility management staff showed the following: The 1/16/08 History and Physical Indicated Patient 1 was 91 year old admitted to the hospital from board and care facility with diagnoses of altered level of consciousness secondary to psychotropic medication (Risperdal), right humeral (arm) fracture resulted from a fall, agitated dementia, anemia and congestive heart failure. The admission orders showed admission to medical/surgical floor on bed rest. On 1/18/08 the physician progress note indicated the plan for Patient 1 was pain control, orthopedic consult and discharge to SNF (Skilled Nursing Facility) in AM. A progress note on 1/19/08 at 11:10 a.m. showed that the SNF was refusing to take the patient today (Saturday) and will accept the patient on Monday (1/21/08). The physician progress note documented on 1/20/08 (no time) that arrangements were made for Patient 1 to discharge on 1/21/08. Review of physician orders showed an order on 1/17/08 at 4:00 a.m. for Haldol (antipsychotic) 0.5 mg intravenously to be given "now" and to repeat in one hour if needed for agitation. On 1/17/08 at 8:30 a.m. an order was written for Haldol 1 mg intramuscular or oral dose every six hours as needed for agitation and "restraints prn (as needed)." The order contained no type of restraints, specific reason and circumstances for its use. There was no plan for progressive removal of the restraints as per P&P for physical restraints (section 14).		**Continued from Page 4** prevention intervention; o Interdisciplinary Plan of Care to insure that a "Yellow Fall Risk armband" selection is available to identify patients at medium and high risk for falls; o Patient Care and Acuity Record to specify the number of side rails up to include a choice of x2, x3 or x4. All patient care staff was in-serviced on the form changes via acknowledgement by 6/22/09. • Concurrent monitoring of all patients in restraints is being conducted using the following criteria: presence of appropriate restraint order and documentation; presence of documentation of use of alternative and less restrictive methods of restrains were attempted prior to restraint application; completion and documentation of patient assessment every two hours for patients in non-behavioral	6/22/09

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	Continued From page 5 The medical record contained Physician Order for Acute Medical/Surgical Restraint form with preprinted reason for restraint: This intervention is required because alternative interventions attempted were found ineffective. The form showed initial order on 1/17/08 for wrist restraints for "disconnecting/removing medical/therapeutic devices." The length of time for the use was 24 hours. The order was renewed on 1/18/08 at 10:00 a.m. with indication added "attempting to get out of bed," also for 24 hours duration. The order was not renewed on 1/19/08. The record contained no evidence of clinical justification and proof that the use of alternatives posed more risk than restraints and what alternatives have been considered and attempted, as per restraint P&P (sections 6.1 and 7.1.2). Patient 1's medical record showed care plan for fall prevention was initiated on 1/16/08 as Patient 1 was identified at high risk for falls. The interventions were: fall risk management such as rails x 4 and fall risk sign. The section "restraint protocol" was not check-marked. There were no updates to the fall care plan. The nurses' notes contained no documentation that Fall Prevention protocol was in effect as per Fall Prevention P&P. The Patient Care Plan did not indicate interventions such as monitoring the patient closely, or placing bed in low position as per P&P. There was no plan of care or any documentation that reflected outcome oriented goals related to the use of restraints ordered on 1/17/08 and 1/18/08. There was no description of interventions and no care plan updates after		Continued from Page 5 restraints and every 15 minutes for patients in behavioral restraints; presence of a valid physician restraint order for each restraint episode; and presence of documentation of all required criteria on the physician restraint orders. The concurrent monitoring will be conducted for the next three months from 622/09, or until compliance goal of 100% for the listed criteria is achieved.	

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	Continued From page 6 restraint intervention was discontinued on 1/19/08, as per P&P for use of restraints (section 19). Review of progress notes for the night shift on 1/19/08 to 1/20/08 showed at 8:00 p.m. Patient 1 removed her identification band, hospital gown, refused blanket, and was uncooperative. At 9:00 p.m. the nurse noted bed alarm was set. There was no documentation showing if bed rails were up or down. The notes indicted the patient was calm most of the remaining night shift and that at 7:00 a.m. report was given to the AM shift. The AM shift nurse documented at 8:00 a.m. the patient was incontinent of stool, hands soiled difficult to clean, right arm edema and purple discoloration from mid-arm to chest area. At 10:30 a.m. the nurse documented that the patient was incontinent and changed. The patient continued to be disoriented moving in bed, was repositioned and was given Haldol for agitation, pulling off brief pants and gown. The next nursing note on 1/20/08 at 12:15 p.m. documented that Patient 1 was found on the floor lying on her left side in fetal position, calling out to get her off the floor. The patient was noted complaining of pain in legs and right arm. The patient was placed back to bed then to Geri chair and the physician was notified at 12:25 p.m. Orders were received for bilateral hip x-rays. At 3:30 p.m. the nurse documented x-rays showed displaced left femur fracture. The record showed radiology report for date of exam on 1/20/08 that indicated clinical impression-ground level fall, with impression documented: displaced left femur fracture.			

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	Continued From page 7 The medical record showed Acute Medical/Surgical Restraint Documentation/Care Plan form was initiated on 1/20/08 and on 1/21/08, after the order for restraint was renewed on 1/20/08 at 4:30 p.m. (after the 1/20/08 fall). The behaviors leading to action were marked as "climbing out of bed despite instructions" and "dislodging lines/tubes." Less restrictive measures were check-marked: verbal de-escalation, medication, full bed rails, positioning, diversional activities and bed alarms. There was no documentation in Patient 1's medical record prior or after the fall to show that all non-physical restraint alternatives have been considered and attempted, such as increased observations and monitoring and the use of a sitter, as per P&P for restraint use (section 7.1.2). RN 1 stated in an interview on 9/19/08 that she was assigned to Patient 1 on 1/20/08 day shift, the day the patient fell. This was the first time she cared for the patient. She received report from the night shift and was aware the patient was considered falls risk and was on fall precautions. Patient 1 had restraints the few days prior to her shift, but the night before her shift and during the day shift on 1/20/08 the patient had only side rails x4, no Posey (waist/trunk restraint). The RN stated that if patient was climbing out of bed she would consider it as a need for restraints. She would consider the side rails x4 first and if ineffective, consider a vest (need a physician order first). The RN stated the patient had side rails up x4 observed on her rounds. The RN found Patient 1 on the floor on 1/20/08 (at 12:15 p.m.) during her 15 minutes rounds. She stated she			

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	Continued From page 8 thought side rails were up when she found the patient. She was not sure if bed alarm was set or not. On 1/21/08 (no time) the physician documented in the progress notes that Patient 1 fell out of bed yesterday and was found to have femur fracture. The patient was noted lethargic, unable to answer questions. The progress notes and anesthesia notes on 1/21/08 indicated the patient was considered for a surgery but surgery was postponed due to the patient's current condition (dehydration and hypokalemia). Progress notes on 1/23/08 indicated that family was advised against surgery and the patient was placed on comfort care. The progress notes indicated Patient 1 expired on 1/23/08.			

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