

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2015
NAME OF PROVIDER OR SUPPLIER Vibra Hospital of San Diego		STREET ADDRESS, CITY, STATE, ZIP CODE 555 Washington St, San Diego, CA 92103-2289 SAN DIEGO COUNTY		
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	<p>The following reflects the findings of the Department of Public Health during an inspection visit:</p> <p>Complaint Intake Number: CA00460462, CA00460756 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 21899, HFEN</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>Health and Safety Code Section 1280.3(g): 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.</p> <p>HEALTH AND SAFETY CODE – HSC</p> <p>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 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:</p>		<p>In order to prevent other patients having the potential to be affected by the same deficient practice, nursing leadership reviewed all patients each shift to determine if the Morse Fall was completed and to ensure all fall precautions were in place for any patients deemed to be at high risk for falls. All immediate and systemic changes are described in detail throughout the Plan of Correction.</p> <p>The "Nursing Flow Sheet" (paper documentation sheet) with the Morse Fall Risk Assessment (approved fall risk assessment) was implemented by the Chief Clinical Officer (CCO). Contracted nursing staff and House Supervisors/Resource Nurses and staff nurses were educated on the change in form. House Supervisors and Resource Nurses verify the fall score each shift with the contracted staff utilizing the flow sheet and enter the Morse Fall Scale in to the Electronic Medical Record (EMR) with the contracted nursing staff if they do not have access to the EMR. House Supervisors and Resource Nurses staff will verify at the time, that the planned care interventions are in place in the EMR. The CCO is responsible for ensuring this process is in place.</p>	<p>0929/15</p> <p>10/08/15</p>

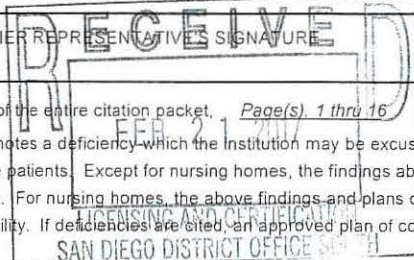
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Jameeka G.



TITLE
CEO

(X6) DATE

2/16/17

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 16

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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	<p>(5) Environmental events including the following (D) A patient death associated with a fall while being cared for in a health facility.</p> <p>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. CDPH verified that the facility informed the patient or the party responsible for patient, of the adverse event by the time the report was made.</p> <p>Title 22 Regulations § 70213. Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. (b) Policies and procedures shall be based on current standards of nursing practice and shall be consistent with the nursing process which includes: assessment, nursing diagnosis, planning, intervention, evaluation, and, as circumstances require, patient advocacy.</p> <p>§ 70215. Planning and Implementing Patient Care. (a) A registered nurse shall directly provide: (2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation. (b) The planning and delivery of patient care shall</p>		<p>Monitoring occurs each shift when Nursing Leadership verifies the Morse Fall Scale has been entered in to the EMR and that the planned care interventions have been implemented. Nursing staff reports to the CCO or her designee on a daily basis the completion of the task utilizing the Best Practice Fall Prevention Audit Tool. The audit includes the following items:</p> <ul style="list-style-type: none"> • Patient Name • Room Number • Date/Shift • Fall Risk Assessment • Fall Risk Score • Verification of the following for patients with a Morse Fall Score 45 or greater (high risk for falling) <ul style="list-style-type: none"> ○ Bed in low position ○ Bed alarm on ○ Call Bell in Reach ○ Care Plan updated to reflect fall status ○ Yellow symbol outside door ○ Yellow Armband ○ Yellow dot on assignment board <p>Monitoring results and data will be presented to the Falls Task Force, Patient Safety Committee, and QAPI/MEC and to the Governing Body.</p>	10/08/15

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	<p>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.</p> <p>§ 70214. Nursing Staff Development.</p> <p>(a) There shall be a written, organized in-service education program for all patient care personnel, including temporary staff as described in subsection 70217(m). The program shall include, but shall not be limited to, orientation and the process of competency validation as described in subsection 70213(c).</p> <p>(2) All patient care personnel, including temporary staff as described in subsection 70217(m), shall be subject to the process of competency validation for their assigned patient care unit or units. Prior to the completion of validation of the competency standards for a patient care unit, patient care assignments shall be subject to the following restrictions:</p> <p>(A) Assignments shall include only those duties and responsibilities for which competency has been validated.</p> <p>The above regulations were NOT MET as evidenced by:</p> <p>Based on interview and record review the hospital failed to ensure that nursing services were implemented to meet a patient's care needs. A nursing assessment for fall risk was not conducted in accordance with hospital policy and procedure. Care plan interventions for fall prevention were not implemented by the nursing staff. In addition, assessments and reassessments to meet patient</p>		<p>The Quality Assurance Performance Improvement / Medical Executive Committee (QAPI/MEC) approved the revised Falls Prevention Program which includes specific guidelines for post fall assessment frequency. New to the policy is a Rapid Response Team (RRT) Trauma Status/Post (S/P) Fall protocol. For every unwitnessed fall or fall with suspected head injury the protocol outlines Neurological Checks every (Q) 15 minutes X 4 and every (Q) 30 minutes X 2. If there is a physical change or neurological status deteriorates, the nurse is to notify the physician immediately and restart the frequency of assessments. This revised Falls Prevention Program was presented to the Governing Body for review, with any suggested revisions being made according to Governing Body recommendations. The CCO is responsible for implementation of this process.</p> <p>Each fall will be audited to verify the RRT Protocol was completed per policy and that frequency of monitoring was completed and documented when appropriate. The Director of Quality (DQM) will report the findings of the audits to the Falls Task Force, Patient Safety Committee, QAPI/MEC and Governing Board. The DQM is responsible for overall implementation of the data collection, aggregation and reporting.</p>	10/28/15

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	<p>care and safety needs were not performed after a fall. Patient 1 fell, sustained a head injury, had a change of condition, which was then diagnosed as a subdural hematoma (bleeding within the brain), and died.</p> <p>Findings:</p> <p>Patient 1 was admitted to the hospital (long term acute care hospital) on 9/16/15 with diagnoses which included multiple skin abscesses (infected skin wounds) and hepatic encephalopathy (a metabolic brain disorder which can occur in advanced liver disease and cause impaired memory and intellectual function) per the physician's Admission History and Physical Examination document, dated 9/16/15. The same document included that Patient 1 was on deep venous thrombosis prophylaxis (an anticoagulant medication regime used to slow blood clotting time and decrease blood clot formation).</p> <p>During an interview on 10/6/15 at 1:00 P.M., the Director of Quality Management (DQM) stated that Patient 1 sustained a fall on the morning of 9/29/15 at approximately 6:30 A.M., while the patient was in a long-term acute care (LTAC) hospital. The DQM stated that Patient 1 developed a change of condition after the fall and was transferred to another Hospital (B - GACH/a general acute care hospital), which was across the street, for emergency services on the day of the fall. The DQM stated Hospital B informed them of the patient's death on 10/2/15.</p>		<p>Mandatory training for all clinical staff was held twice daily on the Morse Fall Scale and requirements for interventions for patients at high risk for falls, prevention, assessments and care plan implementation and documentation was held twice daily with corporate leadership including the Senior Director of Clinical Education, the Corporate Director of Clinical Operations and locally, the Chief Executive Officer (CEO) and DQM. Over 200 staff members were trained in the sessions and a self-study module was created for staff who were unable to attend and for all contracted staff nurses.</p> <p>All contracted nursing staff in the building is required to participate in training and a new process has been implemented to obtain HMS access in order for those staff to document in the EMR. The CCO or their designee is responsible for ensure the contracted nursing staff have the fall prevention module training prior to caring for patients. The DQM is responsible for submitting access requests for contracted staff and requesting priority access request processing, as needed. The CCO will ensure that contracted staff is oriented to the EMR prior to use of the EMR. The CCO will monitor compliance by reporting the number of contracted staff reporting to the building and the number of contracted staff utilizing the EMR. This information will be reported up to the Falls Task Force, Patient Safety Committee, QAPI/MEC and Governing Board</p>	<p>10/10/15 10/11/10 10/13/15 10/13/15 10/14/15 10/16/15</p>

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	<p>During an interview and joint record/document review on 10/6/15 at 2:00 P.M., Medical Doctor (MD) 1 stated that on 9/29/15 at "approximately 7:30" he was on day shift duty and responded to Patient 1's room when a Rapid Response code (special team response for an unstable patient situation) was announced. MD 1 stated he was informed by the nursing staff that Patient 1 had sustained a fall "about an hour ago" and was examined at the time by MD 3, the night duty physician. MD 1 stated he was informed by nursing the patient had developed a change in condition, which involved a decreased level of consciousness since the fall. MD 1 stated he examined the patient and observed a "boggy hematoma" (an abnormal soft formation of blood outside of a blood vessel) on the back of the patient's head. A joint review of MD 1's Chart Note, dated 9/29/15 at 8:19 A.M., described the hematoma as "R (right) occipital (lower back of the head) scalp... large...6 x 8 cm (centimeters) in size..." MD 1 stated, at that time, the patient was non-verbal, unresponsive to pain, had a decreased level of consciousness and that the patient's eye pupils were "poorly responsive" (a symptom of impaired brain function). The same Chart Note and Medication Administration Record (MAR) indicated that Patient 1 had been administered a 10 mg (milligram) dose of Ambien (a sedative medication to induce sleep which can last 8 hours or more) at 11:49 P.M., on the shift of the fall occurrence. Sedative medications have potential side effects which include forgetfulness and impaired judgement/physical function. The presence of those side effect symptoms would be included in the</p>		<p>The Quality Assurance Performance Improvement / Medical Executive Committee (QAPI/MEC) approved the revised Falls Prevention Program which includes specific guidelines for post fall assessment frequency. New to the policy is a Rapid Response Team (RRT) Trauma Status/Post (S/P) Fall protocol. For every unwitnessed fall or fall with suspected head injury the protocol outlines Neurological Checks every (Q) 15 minutes X 4 and every (Q 30 minutes X 2. If there is a physical change or neurological status deteriorates, the nurse is to notify the physician and restart the frequency of assessments. This revised Falls Prevention Program will be presented to the Governing Body for review; with any suggested revisions being made according to Governing Body recommendations. The CCO is responsible for implementation of this process.</p> <p>Each fall will be audited to verify the RRT Protocol was completed per policy and that frequency of monitoring was completed and documented when appropriate. The Director of Quality (DQM) will report the findings of the audits to the Falls Task Force, Patient Safety Committee, QAPI/MEC and Governing Board. The DQM is responsible for overall implementation of the data collection, aggregation and reporting.</p>	10/28/15

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	<p>assessment of fall risk. The MAR indicated the Ambien was administered by RN 2, the patient's primary nurse at the time of the fall. MD 1 stated that "immediately" after this post fall examination of Patient 1, he instructed the hospital staff to call 911 for transport to an emergency department.</p> <p>During an interview on 10/6/15 at 3:00 P.M., the DQM stated that "all" of the hospital patient beds have the built in capability to be alarmed to detect patient exit from the bed. The DQM stated that the bed exit alarm function can be turned on or off manually. The DQM stated that hospitalized patients that were assessed at high risk for falls should have "full" fall prevention interventions in place, which would include an engaged bed exit alarm. The DQM stated that Patient 1 had been previously assessed as a high fall risk, initially on 9/17/15 and on the day shift prior to the fall. The DQM stated the patient's bed exit alarm was not turned on at the time of the fall. The DQM stated that the hospital licensed nursing staff were responsible for the assessment of assigned patients on each shift (7:00 A.M. to 7:00 P.M. and 7:00 P.M. to 7:00 A.M.) The DQM stated the hospital used the Modified Morse Fall Scale (an assessment tool which assigns a numerical value to various patient characteristics and identifies a risk for falls based on a total score). The DQM stated that the Modified Morse Fall Scale was embedded in the hospital electronic medical record (EMR) document and was available for use by the "regular" nursing staff and "some" of the intermittent contracted nurses. The DQM stated that "frequently" scheduled contract nurses had</p>		<p>A new process was developed and implemented by an ad hoc committee of the Falls Task Force that will improve the process of granting access to the EMR for all registry staff. The steps include determination of whether the staff has worked at the facility in the past; the staff member's file will be audited for completeness. If it is determined the staff member does not have access to the EMR, they will complete an "Information Systems External User Access Request Form". The DQM is responsible for submitting access requests for contracted staff and requesting priority access request processing, as needed.</p> <p>The Staffing Coordinator communicated the expectation to all Staffing Agencies currently contracted by the organization and emailed the form, and instructed them that the expectation is that all contracted staff will have to request access to the EMR.</p> <p>Monitoring will occur each shift when contracted staff is brought in and the CCO or their designee will verify that the request form is filled out if they do not currently have access to the EMR. The DQM is responsible for submitting access requests for contracted staff and requesting priority access request processing, as needed, and communicating the login information to the Staffing Coordinator and Nursing Leadership.</p>	<p>09/30/15</p> <p>09/30/15</p>

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	<p>been given training and access to the hospital EMR system; however, some of the less frequently scheduled contract nurses, which included RN 2, had not been given the EMR training or access. The DQM stated that a paper assessment tool, the Medical/Surgical Flowsheet, was available to nurses when the patient EMR was not accessible. The DQM stated the hospital's internal investigation of this fall occurrence had revealed that the paper version of the Medical/Surgical Flowsheet did not include the Modified Morse Fall Scale assessment tool. The DQM acknowledged that use of the Modified Morse Fall scale was an expectation of the hospital, however it had not been made available to licensed nurses who did not have access to the EMR. Instead, the Medical/Surgical Flowsheet included a "Fall Risk Level... 1-low, 2-Med, 3 or confused, disoriented, and/or impulsive." That area of the Patient 1's Medical/Surgical Flowsheet, dated 9/28/15, had been crossed out and handwritten over with the words "See day sheet".</p> <p>A review of the hospital's electronic Patient Assessment Report document, dated 9/28/15 at 7:30 A.M., indicated an assessment of Patient 1's physical status. The same report included the patient's "Morse Fall Risk" assessment which identified a "Morse Fall Scale Total 50.00". The Morse Fall Risk assessment tool identifies total numerical scores of 45 or greater as a high risk for falls. There was no evidence of Patient 1's Modified Morse Fall Scale assessment for the 7:00 P.M. to 7:00 A.M. on 9/28/15, which was the shift of the fall occurrence.</p>			

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	<p>During an interview on 10/6/15 at 3:10 P.M., Registered Nurse (RN) 1 stated that the hospital used the Modified Morse Fall Scale assessment tool on every 12 hour shift, to identify patients at high risk for falls. RN 1 stated that bed exit alarms were to be implemented for patients identified at "high" risk for falls. RN 1 stated it was the joint responsibility of the patient's primary nurse and the assigned Certified Nursing Assistant (CNA) staff to check the bed alarms of "high risk" patients, each shift, and "make sure they are turned on".</p> <p>During an interview on 10/7/15 at 9:45 A.M., CNA 1 stated she was assigned to Patient 1 on the night of the patient's fall occurrence. CNA 1 stated that she was not aware if Patient 1 was at risk for falls and that the patient's fall risk status and fall prevention interventions had not been discussed with the patient's primary nurse (RN 2). In addition, CNA 1 stated it was her responsibility to check patient bed alarms each shift, however, she could not recall if she had checked Patient 1's bed alarm. CNA 1 recalled that she was in the patient's room and with another patient, at the time of Patient's fall occurrence. CNA 1 stated that she heard the sound of a "hard thump" and a call for help from RN 2. CNA 1 stated that the Patient 1's bed exit alarm had not sounded. CNA 1 stated that she summoned other staff assistance, brought an electronic blood pressure machine to the room, and then left as other staff arrived. CNA 1 stated that she did not assess Patient 1's blood pressure and was not instructed to monitor the patient's blood pressure after the fall occurrence.</p>			

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	<p>During an interview and joint record/document review on 10/7/15 at 10:15 A.M., RN 2 stated that he was the nurse assigned as Patient 1's primary nurse on the shift during the Patient's fall occurrence. RN 2 confirmed he was an intermittent contract licensed nurse and worked at the hospital infrequently. RN 2 stated that he received a verbal report from the day shift nurse of the patient's status, which included information of the patient diagnoses and previous shift activity. However, RN 2 stated the patient's fall risk status and fall prevention interventions were not discussed. RN 2 stated Patient 1 was "up with assist...seemed oriented...but weak at the time he returned to bed", at 10:00 P.M. RN 2 stated that the patient was also given a dose of the medication Ambien at that time. RN 2 stated "I thought the patient was at moderate risk for falls". However, RN 2 acknowledged that he had not used the Modified Morse Fall Scale to make that assessment and based his judgement of fall risk on a verbal interaction with the patient. In addition, RN 2 stated he "was not in the habit of alarming the beds of oriented patients." RN 2 stated that he did not have access to the patient's EMR for use of the Modified Morse Fall Scale assessment tools or viewing of patient care plan interventions. RN 2 stated that he used a paper version of an assessment tool (the Medical /Surgical Flowsheet), which did not include the Modified Morse Fall Scale. RN 2 stated that he was in Patient 1's room, attending to another patient, at the time of the fall occurrence, "around 6:30 in the morning". RN 2 stated that a bed exit alarm did not sound, but he noticed Patient 1 had</p>			

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	<p>exited his bed and entered an adjacent toilet area. RN 2 stated that he witnessed Patient 1 "fall over backwards" from the toilet area and directly to the floor with a "loud thump" and strike his head. RN 2 stated that nursing and medical staff responded to a call for assistance and that he had reported to them that the patient had "hit hard". RN 2 stated that MD 3 responded and examined the patient at the time of the fall. RN 2 stated MD 3 gave directions, which included "monitor the patient", however, the specific monitoring and frequency parameters were not identified, clarified, ordered or written. RN 2 stated that he performed 2 blood pressure measurements and "neuro checks (eye pupil response)" between 6:55 A.M. and 7:00 A.M. and "more later". RN 2 stated at 7:40 A.M., he returned to assess Patient 1 and found the patient unable to respond verbally and with a decreased level of consciousness.</p> <p>A joint review of the of Patient 1's Medical/Surgical Flowsheet assessment, dated "9/28/15 PM", revealed no documented evidence of ongoing patient blood pressure measurements or neuro checks from 7:00 A.M. until 7:40 A.M. In addition, a review of the patient's Neurological Assessment Flow Sheet form, dated 9/29/15, revealed no documented evidence that Patient 1 was provided with neuro check assessments between 7:00 A.M. and 7:40 A.M.</p> <p>During an interview on 10/7/15 at 11:30 A.M., RN 3 stated that she was a nursing supervisor and responded to the call for assistance (Rapid Response Code) in Patient 1's room on the day of</p>			
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2/3/2017

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2015
NAME OF PROVIDER OR SUPPLIER Vibra Hospital of San Diego			STREET ADDRESS, CITY, STATE, ZIP CODE 555 Washington St, San Diego, CA 92103-2289 SAN DIEGO COUNTY		
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	<p>the fall occurrence. RN 3 stated that she heard Medical Doctor (MD) 3 give a verbal order for a head CAT scan (computerized axial tomography special radiology test to image disease or injury) and that she began to make arrangements for the procedure. RN 3 stated she needed to call a GACH to arrange for the CAT scan and also arrange for transportation, as this facility did not have onsite site CAT scan services. RN 3 stated the hospital's policy and procedure related to falls included every 30 minute assessment of post fall neuro checks and vital signs (assessment of blood pressure, pulse, respirations, pain). RN 3 stated that RN 2 was an intermittent contract nurse and did not have access to the patient's electronic record. RN 3 stated intermittent contract nurses were provided with a "Quick Orientation Form", but she was not aware if RN 2 had received the form prior to the beginning of the shift. RN 3 stated that RN 2 had "questions" about hospital forms and monitoring after the patient's fall and that she had given verbal instructions to RN 2. RN 3 stated that RN 2 then reported that he discovered that the patient had a change of condition. RN 3 stated that MD 1 was summoned to assess the patient and had ordered 9-1-1 transportation to an emergency department.</p> <p>A review of Patient 1's hospital special physician order form, entitled Venous Thromboembolism Prophylaxis Order Form, dated 9/17/15 included "Heparin (an anticoagulation medication used to slow blood clotting time which has the potential side effect of increased potential of bleeding from injuries) 5,000 units subcutaneously (injection administered within the skin layers) BID (twice</p>				

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	<p>daily)." A review of Patient 1's Medication Administration Record (MAR) indicated the Heparin had been administered as ordered since 9/17/15.</p> <p>During an interview and joint record review on 10/7/15 at 1:00 P.M., the Physical Therapist (PT) reviewed PT Daily Notes, dated 9/28/15. The PT stated Patient 1 required standby assistance with walking, used a forward wheeled walker (rolling device to aid in balance) and that a bed exit alarm was in use. This information was also included in the reviewed PT notes. The PT stated that the patient required prompting to recall instructions and demonstrated cognitive impairment when asked "open ended" questions (answers which would require more than a yes or no response).</p> <p>During an interview and joint record review on 10/7/15 at 1:30 P.M., the Occupational Therapist (OT) reviewed the OT Daily Notes, dated 09/28/15. The OT stated that Patient 1 was not safe to use the toilet independently and needed supervised assistance. In addition, the OT stated that Patient 1 demonstrated "impulsiveness" and was "a candidate for a bed exit alarm." A review of Patient 1's care plan, dated 9/17/15, identified the ongoing problem "FALL AND INJURY RISK" and the objective "FREE FROM FALL AND INJURY". The interventions included "BED EXIT ALARM...LOW BED...YELLOW ARMBAND". In addition, the care plan identified the problem "ALTERED MOBILITY" with interventions that included "ASSIST WITH ADLS (activities of daily living)".</p> <p>Per the hospital policy and procedure, entitled Fall</p>			

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	<p>Prevention and Management Program dated "12/14", "All patients admitted to the inpatient setting will be assessed for fall "risk" using the Modified Morse Fall Risk on admission, each shift...Safety devices will be initiated when indicated according to policy as soon as possible once the patient is assessed as being "at risk" for falling...Fall Risk Assessment: If any of these medical factors are present the patient may be at "risk" for falls...infection, toxic/metabolic...sleep disturbances...Meds...anticoagulant...Impaired mobility...Standard Fall Prevention Interventions: Assess patient's fall risk...each shift...High Risk Fall Prevention Interventions: These interventions are designed to be implemented for patients with multiple fall risk factors... Use for those who score High Risk on the Fall Risk Assessment (>45 on Modified Morse Fall Risk Assessment)...Consider use of safety technology for fall prevention...Yellow wristband...Bed and chair alarm...Assessment of the patient post fall: Obtain vital signs and neuro checks when appropriate..."</p> <p>Per the hospital policy and procedure entitled Assessment and Reassessment, dated 10/22/13 "Patients at [name of hospital] receive care based upon a documented assessment of patient care needs and problem identification...Patient needs, response to treatment/intervention, and change in condition or diagnoses are reassessed as necessary and a minimum of every shift...The routine re-assessment of patient's status includes a system review every shift (12 hours)...Documentation of the (re)assessments will be entered into the Electronic Medical Record</p>				

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	<p>(EMR)."</p> <p>Per the hospital policy and procedure entitled Nursing Care Planning, dated "5/14", "It [care plan] communicates pertinent patient problems/needs, delineates appropriate medical and nursing interventions to meet these needs, and documents the effectiveness of the interventions in the medical record."</p> <p>According to the hospital policy and procedure entitled Patients' Rights and Responsibilities; dated "11/13", "Expect emergency procedures to be implemented without unnecessary delay...Personal Safety. The patient has the right to expect safety insofar as the hospital practices and environment are concerned."</p> <p>A review of Hospital B's Emergency Record, dated 9/29/15, indicated that Patient 1 arrived via paramedic transport at 8:04 A.M. The Emergency Record included "This patient [Patient 1] presents with profound depressed mental status, status post report of fall with head trauma. He is in critical condition and is severely encephalopathic (decreased brain functions) and is not protecting his airway. He required emergent endotracheal intubation (insertion of a tube to assist breathing)...Impression: Acute encephalopathy status post fall...Acute neurologic failure status post mechanical fall...Acute respiratory failure status post mechanical fall." A Neurosurgical Consultation (brain specialist) report, dated 9/29/15, indicated that Patient 1 was diagnosed with an acute subdural hematoma (bleeding within</p>			

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	<p>the brain). The Hospital B Death Summary report, dated 10/2/15, included "Chief Complaint: Fall, bilateral subdural hematoma, uncal herniation (damage to the brain stem from increased pressure), right parietal occipital (back of skull) fracture... Discharge Diagnosis: Brain death".</p> <p>During an interview and record/document review on 10/13/15 at 11:00 A.M., the DQM acknowledged that Patient 1's safety had not been maintained when the patient's risk for falls had not been assessed, on the shift of the fall occurrence, per the hospital's policy and procedure. The DQM acknowledged that the patient's bed exit alarm, which had been identified as a care plan fall prevention intervention, had not been implemented at the time of the patient's fall. In addition, the DQM acknowledged policies and procedures for nursing assessment and care planning and post fall nursing care had not been implemented as planned. In addition, the DQM acknowledged that the hospital post fall policy and procedure was not specific, and post fall assessments were not conducted in a manner that met the needs of a patient who had sustained a witnessed fall and head injury.</p> <p>On 10/14/15 at 8:00 A.M., the DQM and the Chief Executive Officer (CEO) were informed of the potential for an administrative penalty.</p>			

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	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 1280.3(g).				

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