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
	054110	A. BUILDING ______ B. WING ______	12/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fremont Hospital	39001 Sundale Drive, Fremont, CA 94538-2005 ALAMEDA COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00512985 - Substantiated Representing the Department of Public Health: Surveyor ID # 2241, 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 1280.3(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. The following reflects the findings of the California Department of Public Health during the investigation of an Entity Reported Incident: CA00512985 The investigation of CA00512985 was conducted from 12/05/16 through 12/16/16. Representing the Department: 27351, HFEN The State Regulations that were violated: Title 22: 71557(a) Health and Safety Code: 1279.1(b)(7) The inspection of the facility was limited to this specific Entity Reported Incident and does not		Title 22: 71557(a) Health and Safety Code: 1279.1(b)(7) Corrective Action The Interim Director of Nursing (DON),	

Event ID:1FR811 5/3/2017 11:08:43AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Interim CEO (X6) DATE: 5/16/17

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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	represent the findings of a full inspection of the facility. 71557(a) If a hospital subject to the provisions of this chapter does not maintain an emergency medical service, its employees shall nevertheless exercise reasonable care to determine whether an emergency exists, render necessary life saving first aid and shall direct the persons seeking emergency care to the nearest hospital which can render the needed services and shall assist the persons seeking emergency care in obtaining such services, including transportation services, in every way reasonable under the circumstances. 1279.1(b) For purposes of this section, "adverse event" includes any of the following: (7) An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor. 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. Based on observation, interview and record review, the hospital failed to recognize that emergency care was needed, and did not promptly intervene when Patient 1, during the course of her stay, became severely dehydrated, hypotensive, and stopped breathing. This adverse event constituted an immediate		Medical Director and Director of Risk Management/ Performance Improvement (RM/PI) reviewed and revised hospital policies including, but not limited to the following: • "First Aid-Medical Emergencies and "Change/ Worsening of Patients Condition" to create one new policy called "Medical Emergencies and Acute Change in Condition". The new policy provides clarification and additional guidance to the nursing staff regarding identification of acute changes in patient condition and their ability to initiate calls to 911 in the event of any such change in a patient's condition that is potentially life threatening. • "Code Blue" - clarified procedure for initiating code blue, enhanced emergency equipment, and identified centralized equipment storage location to improve access. In addition, a new Code Blue Record was created to document code activity as well as a new Code Blue Critique form to assist in the evaluation and identification of performance improvement opportunities. • "Vital Signs" to include abnormal parameters and notifications of physicians and revised Vital Signs Worksheet to include patient's vital signs, evidence of RN's review and intervention. • "RN Daily Nursing Assessment" in include signs and symptoms of dehydration and notification of the medical team. • "Opioid Withdrawal Assessment/ Protocol" to include assessment of opioid withdrawal and detoxification and nursing care measures per the revised assessment and protocol.	12/13/16 1/27/17 v1 4/21/17 v2 1/27/17 1/27/17 4/4/17

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	jeopardy (IJ) which placed the health and safety of Patient 1 at risk when the hospital staff failed to recognize the need for lifesaving interventions and Failed to render the needed first aid. This lack of recognition resulted in Patient 1's Death. Findings: A review of the facility wide, 24 hour, color closed circuit surveillance footage, for the date of 12/3/16 from 5:12 p.m. until 6:10 revealed the following: 5:12 p.m. - Patient 1 was observed walking down the hallway with her arms/hands out in front of her in a fixed contracted position. Patient 1 stopped at the nursing station, crouched down for less than a minute, got up and walked into the Multi-Purpose room (located across from the nursing station). Patient 1 sat at a table, and placed her head on the table. 5:14 p.m. - Patient 1 spoke to another patient who gave Patient 1 a cup, but after trying to pick up the cup with both hands, Patient 1 spilled the beverage in the cup on the table. The other patient gave her another cup. Patient 1 didn't attempt to pick up the second cup. 5:17 p.m. until 5:21 p.m. - Patient 1 was slumped over in a chair when Staff 1 and Staff 2 went into the Multi-Purpose room to check on Patient 1. Staff 1 and Staff 2 attempted to straighten/reposition Patient 1 in her chair for approximately 3 minutes until eventually placing Patient 1 into another chair.		The Interim DON created a new policy "Rapid Response Team" to assist nursing staff to differentiate between a medical emergency and a true code blue. The Rapid Response Team (RRT) responds to patients who exhibit deterioration in physical condition and require immediate nursing or medical intervention for stabilization. The Interim DON developed and incorporated a treatment protocol for Persistent Vomiting and/or Diarrhea in the new policy "Medical Emergencies and Acute Change in Condition" which included: - Notification of the attending physician and medical provider for orders and assessment - Starting patient on clear liquid diet for three days - Obtaining orthostatic vital signs including oxygen saturation monitor four times a day x there days - Monitoring food and fluid intake for three days The DON revised the Pre-admission Nurse to Nurse Report to include information related to vomiting/diarrhea and last PO intake prior to patient transfer. The new and revised policies, procedures, protocols, and flowsheets were reviewed and approved by the Medical Executive Committee and Governing Body. The Interim DON/Staff educator revised the Licensed Nurse Orientation and annual retraining to include the following elements related to patient assessment and care: - Assessment of opioid withdrawal and detoxification and nursing care measures per the revised assessment and protocol - Assessing and treating signs and symptoms of dehydration.	2/15/17 1/3/17 1/3/17 Start 1/3/17 - 4/21/17 4/21/17

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	Staff 2 gave a sip of beverage to Patient 1; having to hold the cup for her to drink. 5:22 p.m. - 5:30 p.m. - Staff 3 entered the Multi-Purpose room to take Patient 1's vital signs. Patient 1 was observed swaying, moving around, restless and weak, unable to sit straight in chair, still falling and slumping over. Staff 3 attempted to take Patient 1's blood pressure. Staff 2 then attempted to take Patient 1's blood pressure using the same automatic BP cuff. Staff 3 left the Multi-Purpose room after a verbal exchange with Staff 2. Staff 3 returned with a manual blood pressure (BP) cuff. Patient 1 placed her head back on the table. Staff 2 took Patient 1's blood pressure using the manual BP cuff. Staff 2 wiped the spilled beverage on table, while Staff 3 left the Multi-Purpose room again, bringing back a wheel chair. Staffs 1, 2, and 3, placed Patient 1 into the wheelchair. Staff 1 then rolled Patient 1 into the Seclusion/Observation room located to the right of the nursing station. 5:30 p.m. - 5:39 p.m. - No observation of any phone calls made by Staffs 1 and 2 at the nursing station were made. Staffs 1 and 2 were observed doing paperwork at the nursing station desk. While Staff 1 was faxing and using copier at the nursing station she glanced at a video monitor located in front of Staff 2. 5:40 p.m. - 5:41 p.m. - Staff 1 looked at the video monitor then went into the medication room. 5:41 p.m. - Patient 1 was observed getting out of		- Revised nurse to nurse documentation for transfers to include nausea/vomiting and oral intake - New protocol for assessment/care when a patient has persistent vomiting/diarrhea - Proper documentation of intake and output including specific number of units and communication with physicians about I&O deficits. - Proper technique for obtaining vital signs, abnormal parameters, and requirement to contact the physician for abnormal readings - Revised vital signs worksheet - Recognition of change in patient condition that constitute a medical emergencies - Timely initiation of emergency nursing care measures for change in condition - Timely initiation of rapid response, code blue, and 911 calls – including the revised Code blue forms and enhanced centralized equipment Training The Interim DON/designee provided education to all RN's on assessment and care of patients as outlined in the revised and newly developed policies, procedures, protocols, and flowsheets, to include the following: - assessment of opioid withdrawal and detoxification and nursing care measures per the revised assessment and protocol - assessing and treating signs and symptoms of dehydration. - Revised nursing daily assessment to include sign/symptoms of dehydration - Revised nurse to nurse documentation for transfers to include nausea/vomiting - and oral intake - New protocol for assessment/care when a patient has persistent vomiting/diarrhea	4/21/17

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	bed, unbalanced and stumbling. Patient 1 fell to the floor in the observation room. 5:42 p.m. - 5:45 p.m. - Staff 2 looked into the observation room window. Both Staff 1 and Staff 2 entered the observation room and found Patient 1 on the floor, assisted Patient 1 back to the bed and left the observation room after speaking to Patient 1. 5:45 p.m. - 5:49 p.m. - Patient 1 was unobserved by staff either directly or by video surveillance. 5:49 p.m. - 5:50 p.m. - Staff 1 made a phone call at the nursing station then observed Patient 1 through the observation room window; Patient 1 was seen kneeling at the bedside with a brownish fluid-like substance on the bed in front of her. 5:50 p.m. - Staff 1 entered the observation room and looked at the brown fluid-like substance on the bed. Patient 1 was lying on the floor on her side next to the head of the bed and not moving. Staff 1 took the bed linen off of the bed and threw the linen in the alcove area of the observation room and walked back to the foot of bed. Staff 1 looked at Patient 1 while standing at the foot of the bed (Patient 1 moved her arm). Staff 1 walked to the head of the bed, repositioned Patient 1's pillow on the bed, then bent down to check on Patient 1, who was still on the floor. 5:51 p.m. - Staff 3 looked into observation room, then went back to assisting another patient at the nursing station, and then went into the alcove area of the observation room. Staff 3 wasn't seen on the		- proper documentation of intake and output including specific number of units and communication with physicians about I&O deficits. - proper technique for obtaining vital signs, abnormal parameters, and requirement to contact the physician for abnormal readings - Revised vital signs worksheet - recognition of change in patient condition that constitute a medical emergencies - timely initiation of emergency nursing care measures for change in condition - Timely initiation of rapid response, code blue, and 911 calls – including the revised Code blue forms and enhanced centralized equipment storage Trainings were completed in small group settings and/or individually by 4/21/17. Any staff not trained by 4/21/17 received training prior to the beginning of their next shift. Competency was assessed through return demonstration and/or post-test as appropriate to the task. The Interim DON/designee provided MHT's, LVN's and LPT's re-training on proper technique for obtaining vital signs, abnormal parameters, I&O documentation and requirement to contact the RN for all abnormal readings in group settings and individually. Staff that did not complete training by 4/21/17 was trained prior to their next shift. Competency was assessed through return demonstration. The Medical Director provided training to all members of the medical staff on their responsibilities for oversight of patient treatment to include detox protocols and patient assessments completed by the nursing staff. Additionally, they were trained	4/21/17 4/21/17 4/21/17

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	video at this point. Staff 1 appeared to speak to Staff 3. 5:52 p.m. - 5:55 p.m. - Staff 1 and Staff 3 were seen attempting to sit Patient 1 up against the wall closest to the doorway by the alcove area of the observation room. Staff 1 left the observation room. Patient 1 appeared pale, weak, unable to sit up straight, her lips had a bluish tinge with her body slumping. Staff 3 was seen still in the alcove area approximately 2 - 3 feet away from Patient 1 while she was positioned against the wall facing away from Staff 3. Staff 3's face wasn't seen on video at this point. 5:55 p.m. - Both Staff 1 and Staff 2 on phone calls at the nursing station. Staff 4 entered the nursing station. 5:57 p.m. - Staff 1 retrieved a manual BP cuff and re-entered the observation room at 5:58 p.m. Staff 1 was seen appearing to check for a pulse; Staff 1 verbalized something to Staff 3 who was still in the alcove area. Staff 3 left. Staff 1 knocked on observation room window and began CPR (Cardio-Pulmonary Resuscitation used as a life saving measure). Staff 4 entered the observation room to assist in CPR efforts for Patient 1. 5:58 p.m. - 6:08 p.m. - The Code Blue team along with Staffs 1 and 4 continued CPR efforts. 6:08 p.m. - Paramedics/EMTs arrived and took over CPR efforts.		on the revised code blue policy and the new Rapid Response policy and their responsibilities for responding to codes called when they are in-house and directing staff appropriately. Monitoring The Interim DON initiated Code Blue and Rapid Response Drills to provide nursing staff an opportunity to practice and improve nursing skills required in medical emergencies. Drills of each type (code blue and rapid response) are conducted 3 times per week one per shift. For a period of four months or until 100% is achieved and maintained for at least three months, the Interim DON/designee is auditing 100% of Code Blue and Rapid Response Drills evaluations to ensure a timely response and demonstration of staff proficiency. Identified deficiencies are addressed immediately with staff through re-education and/or corrective counseling. Continued non-compliance may result in corrective actions up to and including termination. Aggregated data regarding Code Blue and Rapid Response drills is reported to the PI Committee and MEC monthly and quarterly to the Governing Body. For a period of four months or until 100% compliance is achieved and maintained. The Interim DON/designee is auditing s 100% of all patients transferred to medical facilities and Rapid Response Codes to ensure prompt identification of change in condition and timely nursing interventions. Areas of deficiency will be addressed with staff immediately through re-education and/or corrective counseling.	4/7/17 4/21/17

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6:10 p.m. - Paramedics/EMTs pronounced Patient 1 dead.

Review of the Admission and Nursing records showed that Patient 1 was a 22 year old admitted to the hospital on 12/2/16 at 1:30 p.m. Patient 1 was transferred from another General Acute Care Hospital (GACH) after being brought in by a family member on 12/1/16 due to suicide threat. Patient 1 also had positive drug toxicity screens for the following substances; amphetamines, methamphetamines, benzodiazepines, opiates (heroin), and cannibus. The record showed also that Patient 1 admitted to a family member that she had been using heroin daily and had been homeless for a period of 4 months during 2016, just prior to this hospitalization. Patient 1 also had a history of Asthma.

Continued record review showed that Patient 1 was exhibiting opiate (heroin) withdrawal symptoms prior to her transfer to this facility (Increased vomiting, agitation, restlessness, and anxiety) Patient 1 had four episodes of vomiting prior to her transfer to this facility from another hospital where she stayed from 12/1/16 to 12/2/16.

In an interview on 12/5/16 at 1:30 p.m., Physician 1 (PHYS 1) stated that Patient 1 was accepted for transfer from the GACH and that he placed her on an opiate withdrawal protocol. PHYS 1 stated he did not order any antidepressant medications for her because he wanted to get her withdrawal from opiates under control and out of the way before addressing her depressive symptoms. PHYS 1

Continued non-compliance may result in corrective actions up to and including termination.
Aggregated data regarding Code Blue and Rapid Response drills is reported to the PI Committee and MEC monthly and quarterly to the Governing Body

For a period of four months or until 100% compliance is achieved and maintained. The Interim DON/designee is auditing s 100% of all patients transferred to medical facilities and Rapid Response Codes to ensure prompt identification of change in condition and timely nursing interventions. Areas of deficiency will be addressed with staff immediately through re-education and/or corrective counseling. Continued non-compliance results in further corrective actions up to and including termination. Aggregated data is reported to the PI Committee and MEC monthly and quarterly to the Governing Body — 4/21/17

The Interim DON/designee is auditing the proper technique of obtaining vital signs through direct observation of nursing staff a minimum of one staff per unit per shift per day for 90 days. Re-education is provided immediately as indicated.
After 90 days, monitoring may be reduced to one staff per unit per shift per week for a period of 6 months. Aggregated data is reported to the PI Committee and MEC monthly and quarterly to the Governing Body. Non-compliance will be addressed through additional training and/or disciplinary action as appropriate. — 4/21/17

For a period of four months or until 100% compliance is achieved and maintained, the Interim DON/designee is auditing the documentation of 100% of all I/O's ordered to — 4/21/17

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	stated the internist/medical group had not seen Patient 1 by the time he saw her on 12/2/16. PHYS 1 stated he was aware that Patient 1 was experiencing restlessness, agitation, anxiety, and increased vomiting prior to the Patient 1's transfer to this facility. PHYS 1 ordered Ativan (used to calm anxiety) to help Patient 1 cope with her withdrawal symptoms. When asked how the other polysubstance that Patient 1 had in her system affected the patient's opiate withdrawal, PHYS 1 stated that this was a better question for the internal medicine physician, but that it could affect her physical presentation. The "Psychiatric Evaluation" dated 12/2/16 showed Patient 1's main complaint was "Sick", and that Patient 1 reported that she had been using heroin daily for, "A long time"; 1 gram a day. The evaluation showed that Patient 1 was complaining of stomach cramping, nausea, and that she was, "Clearly medically distressed". Further review of the psychiatric evaluation done by PHYS 1, showed that PHYS 1 felt that Patient 1 was a heroin addict, possibly addicted to methamphetamines, and needed detoxification first. The Physician's, "Opiate Withdrawal Standing Order" dated on 12/2/16 at 10:30 a.m. showed that staff was to assess and rate Patient 1's symptoms on the "Clinical Opioid Withdrawal Symptoms/Scale" (COWS) sheet and take Patient 1's vital signs every 4 hours for three days. A physician order also dated on 12/2/16 at 2:14 p.m. showed that Patient 1 was to have her intake and output (I & O's) monitored for three days, and to be		verify complete and accurate documentation. Aggregated data regarding recording of I/O's is reported monthly to the Medical Executive Committee and quarterly to the Governing Body. Non-compliance will be addressed through additional training and/or disciplinary action as appropriate.	

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given Gatorade (usually given for fluid and electrolyte replacement) three times a day.

A document titled, "Intake Monitoring Form" dated for 12/2/16, showed that although Patient 1 had an order for Intake and Output monitoring to be done at 2:14 p.m., there was no indication of fluids documented for Patient 1 until 6:15 p.m. when the following was documented for beverage: "water one offered, 100 consumed, orange one offered and 100 consumed, and apple one offered and 100 consumed." There was no indication of whether the "100" was milliliters (ml) or percentages. There was no output documented on the form.

Continued review of the "Intake Monitoring Form" dated 12/3/16, showed on the night shift the following documentation: At 6:00 a.m., "Orange Juice x3, offered 360 milliliters (ml) and consumed 360 ml, water x2, 240 ml offered and 240 ml consumed, 1 water x2, 240 ml offered and 240 ml consumed, and milk 3 grams, 708 ml offered and 708 ml consumed." On day shift, the following was documented: At 8:00 a.m., "water, 200 ml offered and 100 ml consumed, water 200 ml offered and 100% consumed." Further review of the same document showed that on the evening shift with no time indicated, under snack, Patient 1 had "one water offered, with 30% consumed, and one bottle of Gatorade offered and 20% consumed." There was no indication of how many ounces or milligrams both the Gatorade or water containers held, and this was the first time Gatorade was documented on the intake form. There was no output documented on the intake form.

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A nursing progress note dated 12/3/16 at 7:50 a.m., showed that "patient also observed to be vomiting, per evening nurse; patient vomited and filled one whole basin. patient noted to be inducing vomiting. patient with signs and symptoms of withdrawing from opioids. patient was able to fill another basin of vomitus at end of shift, noted liquid type, no food contents. patient is on intake and output. Vital signs rechecked at 6:50 a.m., BP 144/88, T 98.8, P 85, Resp 20 and Oxygen saturation (O2 Sat) of 100 percent."

Further review of a nursing progress note dated on 12/3/16 at 9:15 a.m., stated that, "staff witnessed patient induced vomiting in her room, earlier report nurse reported that patient was inducing to vomit after report found a garbage with one and one half a cup of brownish liquid bits of semi formed particles. Later patient up and encouraged to eat breakfast, patient appears with tactile hallucinations. Fingers were crossed and states that there's something wrong with my fingers and walked off." There was no nursing progress note indicating what nursing action was taken.

Review of the COWS document showed that Patient 1 was having multiple episodes of vomiting since her admission to the facility on 12/2/16. Continued review of the COWS form showed that on 12/3/16 at 10:50 a.m., Patient 1's sitting BP was 117/65, P 97, Resp 18, T 97.9, and she had a O2 Sat of 90 percent. Vital signs were taken again while standing at 10:50 a.m. and BP was 93/60, P 84, Resp 18, T 97.9 and O2 Sat of 90 percent. There

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was no nursing note showing that the physician was notified or of the urgency of the change in Patient 1's condition.

A physician's progress note dated on 12/3/16 at 3:30 p.m. showed that Patient 1 stated that she wasn't feeling good, that she was dizzy and tired. The physician note showed that her vital signs should be taken now and monitored closely for any changes. There was no corresponding physician's order placed.

A physician's order dated on 12/3/16 at 4:00 p.m., showed, "metabolic panel (labwork which includes electrolytes) including calcium to be done in a.m. order stat (immediately)." There was no documentation of lab work being done on the same date ordered.

A nursing progress note dated on 12/3/16 at 7:00 p.m. showed that at 5:00 p.m. Staff 1 observed Patient 1, "Having body contractions, (stiffening) sliding down on her chair and that Patient 1's vital signs were BP 86/56, P 84, and her O2 Sat percentages were fluctuating between 93 and 96. There was no corresponding nursing intervention documented after this nursing assessment.

In an interview on 12/5/16 at 3:00 p.m., Staff 3 stated 12/3/16 was the first time that he had seen or met Patient 1. During the shift report it was indicated that Patient 1 had a history of substance abuse. Staff 3 stated that Physician 2 (PHYS 2) spoke with Patient 1, then about 5:30 p.m., Patient 1 really wanted help from the nurses, water was

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given to her, but she spilled it. It was noted that the patient's arms were contracted, her arms were being held outwards, and she couldn't hold onto a water cup. Staff 3 went on to state that during her vital signs being taken, Patient 1 complained that the cuff was causing her pain, so Staff 3 got the manual blood pressure for Staffs 1 & 2. Staff 3 stated that Patient 1 was in the observation room when Staff 1 asked that Staff 3 come in to assist, and when Staff 3 walked in to sit with Patient 1, she had vomited so he sat her up, "Cause I didn't want her to aspirate". Staff 3 stated Patient 1 was mumbling incoherently and that when Staff 1 returned to the observation room, Staff 1 told Staff 3 to call 911 and to get oxygen, and a code blue was called.

In an interview on 12/5/16 at 3:50 p.m., Staff 4 stated Staff 1 paged her and asked for assistance, "Because he thought that he [Staff 1] would have to send Patient 1 out to the emergency room". Staff 4 stated that PHYS 2had Okayed Patient 1 to be transferred to the emergency department, but PHYS 2 instructed Staff 1 to go and check on Patient 1 to see if they needed to call 911 instead of sending her by regular transfer to the emergency department, "Because sometimes it takes longer to send by regular transfer". When Staff 1 checked on Patient 1, he called out for Staff 3 to call 911; Patient 1 had vomited and was unresponsive.

In an interview on 12/6/16 at 1:00 p.m. Physician 3 (P3) stated, "Generally the hospital will need to use this incident as a learning moment based mostly on when to activate Advanced Cardiac Life Support (ACLS), Basic Life Support (BLS); and when to call

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	054110	A. BUILDING ______ B. WING ______	12/16/2016

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911 versus when to transfer. Staff needs to be more proactive than reactive and a protocol would have to be developed/put in place related to the signs and symptoms of severe dehydration." P3 further stated he believed possibly that Patient 1's contractures all of a sudden were due to electrolyte imbalance heightened or due in part to the opiate withdrawal signs and symptoms compounding her presentation, and more than likely she possibly aspirated (inhalation of a foreign body into the lungs; usually fluid or food).

In an interview on 12/6/16 at 4:10 p.m. Staff 2 stated, "PHYS 2 saw Patient 1 with contractures and that Patient 1 stated that she couldn't walk but was then able to and PHYS 2 ordered STAT lab work for the following morning. Staff 2 stated that a new admission came and then another patient on the unit came to the nursing station to say that Patient 1 needed help in the Multi-Purpose room because she was knocking her cup over; her leg looked like she was cramping, we tried to reposition her we couldn't so we put her in another chair. Looked like she couldn't take the automatic blood pressure cuff. I thought something was wrong, looked out of it. She didn't look right, wasn't there. The automatic blood pressure cuff wasn't working. Manual blood pressure cuff had to be taken, blood pressure was really weak and low; 86/50 something. I was wanting to transfer her out then, Staff 1 said no, her O2 Sat was low too, though...she was able to bend her leg again by the time the wheelchair came to go to the observation room and Patient 1was talking...". When asked if Staff 2 wanted to transfer Patient 1 out to the emergency department

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why didn't she, Staff 2 stated that she was new and didn't really know what the policy was.

In an interview on 12/6/16 at 5:15 p.m., PHYS 2stated, Patient 1 had increased anxiety, was restless, and not interested in talking much. She was complaining of wrist pain, spasms, and mentioned that she was dizzy, and complained of tiredness. PHYS 2stated that Patient 1 threw herself onto the floor and she felt it was purposeful. PHYS 2looked at her lab work because the main concern was about dehydration after seeing the opiate withdrawal protocol. PHYS 2stated she ordered a metabolic lab panel and told the staff to watch her and let PHYS 2know what's happening or if there were any changes.

In an interview on 12/12/16 at 4:35 p.m., Staff 1 stated the day shift staff had informed him of Patient 1 vomiting even in the GACH, and that she had been vomiting on the unit. Staff 1 stated it was also reported that Patient 1 may have been purging (self-induced vomiting), but that she had contractures. (An abnormal decrease in electrolytes can cause muscle rigidity. Continuous vomiting facilitates the loss of electrolytes) Staff 1 stated that he and PHYS 2saw Patient 1 for the first time at the nursing station and her arms were contracted and that Patient 1 asked to have IV (intravenous) fluids started. Staff 1 stated that he was trying at some point to find out if Patient 1 could be transferred to the Medical Floor of the facility so that an IV could be started. Staff 1 then stated that a new admission came and he did not see Patient 1 until around 5 p.m. when he noticed that now her legs

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were contracted. Staff 1 stated that Staff 2 tried to take an automatic blood pressure but was unable to get one, and he felt that it just wasn't registering. A manual blood pressure was taken then and it was 86/56. They tried to reposition Patient 1 in her chair and ended up changing her to another chair because her seat was wet. Finally, Patient 1 was paced in a wheelchair and placed her in the observation room to monitor her. When asked what the sign and symptoms of dehydration were, Staff 1 stated poor skin turgor (skin elasticity), dry parched lips and skin, risk if vomiting a lot, cramping, and drop in blood pressure or change in vital signs. When asked if a blood pressure reading of 86/56 was of a concern, Staff 1 stated that it was. When questioned if Staff 1 had checked Patient 1's medical record, vital signs and history after Patient 1's blood pressure registered 86/56, Staff 1 replied that he only had a couple of hours to get a lot of other tasks completed on the unit.

On 11/2016, a review of the hospital's Policy and Procedure titled, "First Aid-Medical Emergencies" revealed, "Is not a medical hospital and does not provide emergency medical treatment. In the event of a life threatening emergency, patients will be transferred for evaluation and care to appropriate facility." The policy further showed, "Staff must continually assess for signs of physical distress in all patients. Appropriate and rapid staff response to medical emergencies can save a patient's life."

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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).			