

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050746	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/27/2007
NAME OF PROVIDER OR SUPPLIER WESTERN MEDICAL CENTER SANTA ANA		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH TUSTIN AVENUE, SANTA ANA, CA 92705 ORANGE COUNTY		
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	<p>The following reflects the findings of the Department of Public Health during the investigation of COMPLAINT NO: CA00134451</p> <p>Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility.</p> <p>Representing the Department of Public Health: [REDACTED]</p> <p>1280.1 (a) If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars (\$25,000) per violation.</p> <p>(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.</p> <p>DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY</p> <p>70213(a)(b) Nursing Service Policies and Procedures.</p> <p>(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.</p>			

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8/25/2008

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OCT 9 2008

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



DAN BROTHMAN, CHIEF EXECUTIVE OFFICER

TITLE

(X6) DATE

9/10/08

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	<p>Continued From page 1</p> <p>(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>70707(b)(2)(d) Patients' Rights.</p> <p>(b) A list of these patients' rights shall be posted in both Spanish and English in appropriate places within the hospital so that such rights may be read by patients. This list shall include but not be limited to the patients' rights to:</p> <p>(2) Considerate and respectful care.</p> <p>(d) All hospital personnel shall observe these patient rights.</p> <p>The above regulations were NOT MET as evidenced by:</p> <p>Based on interview, clinical record review, and review of policies and procedures, the facility failed to investigate and notify family members of an adverse event for Patient #1. An allegation of physical assault was documented in the clinical record for Patient #1 on 11/18/07. Patient #1 complained to staff that she was slapped by a staff member and suffered a bruise to her face. The allegation was not reported to the family and not investigated by the hospital according to their policies and procedures. This resulted in a failure to protect the patient from the potential of abuse and to afford Patient 1 the right to considerate and respectful care.</p>		<p>Western Medical Center Santa Ana requests an informal conference with the District Administrator/ District Manager of the local DPH office.</p> <p>70707(b)(2)(d) <u>Responsible Person: Director, Gero Psych Unit</u> In-service to staff regarding reporting issues relating to documentation in plan of care, timely notification to family and supervision of reportable events, and investigation of events.</p> <p>Patient was interviewed by Director of Gero Psych Unit.</p> <p>Disclosure was made to family by Director of Gero Psych Unit.</p> <p>Staff interviewed by Director of Gero Psych Unit.</p> <p>Quarterly hour observations were conducted, documented and monitored for fall and aggressive behavior during the admission -11/16/07 – 12/4/07</p> <p>Safety measures were assessed each shift for bed position and locked side rail position, non-skid footwear, call light within reach, fall precautions during the admission 11/14/07 – 12/4/07.</p>	<p>12/17/07</p> <p>11/19/07</p> <p>11/20/07</p> <p>11/21/07</p> <p>11/16/07</p> <p>11/14/07</p>

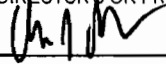
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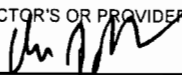
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	<p>Continued From page 2</p> <p>Findings:</p> <p>On 12/27/07 at 1335 hours, a clinical record review was conducted for Patient #1.</p> <p>The licensed nurse documented on 11/18/07 at 0800 hours, that Patient #1 had bruising to the maxilla area of her face. The documentation failed to show that the nurse asked the patient what happened. Photographic evidence dated 11/18/07, showed Patient #1 to have a bruised area underneath the right eye. At 1350 hours, Physician X rounded and documentation by the licensed nurse showed the physician was notified of Patient #1's condition.</p> <p>A psychiatric progress note, dated 11/19/07, showed Patient #1 told him she was hit by staff and then laughed at. The licensed nurse's note dated 11/20/07 at 1745 hours, revealed documentation of a bruise to the right eye.</p> <p>On 11/21/07 at 1242 hours, the recreational therapist documented Patient #1 stated, "A staff has punched my face and then he tried to get me to eat my fist." At 1400 hours, the licensed nurse documented Patient #1 complained of "care taker abuse."</p> <p>A photograph dated 11/26/07, showed the lower portion of Patient #1's right eye to have a bruise that mirrored the curvature of the lens of her eye glasses that she was holding in the photograph.</p> <p>On 1/2/08 at 0920 hours, an interview was</p>		<p>Additional in-services have been provided to physicians, social workers and staff on 6/20/08, 7/22/08, 7/29/08, 7/31/08, 8/7/08, 8/8/08, 8/14/08 and 8/18/08, regarding reporting issues:</p> <ul style="list-style-type: none"> To identify the reporting time frames for reporting events. To identify three reportable events To identify agencies to be notified To review of "Never 28" list. <p><u>Ongoing Monitoring:</u></p> <p><u>Responsible Person:</u> Nursing Director, NeuroPsychiatric Unit and Program Director, NeuroPsychiatric Unit</p> <ul style="list-style-type: none"> Notification to outside agencies will be documented and reported in a timely manner in the medical record. This includes APS, SAPD, and CDPH. Chart reviewed by the Nursing Director of the Unit to assess documentation compliance. Tool has been developed that will be completed on all allegations of abuse/neglect. Tool will be completed by social workers and faxed to Quality Management and 	

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	<p>Continued From page 3</p> <p>conducted with the Nursing Director of the Neuropsychiatric Unit. He stated he was made aware of Patient #1's claim she was hit by a staff member on 11/18/07. He stated that reporting and investigation of the alleged assault did not occur promptly, as one staff member was on vacation and the other was not available. The Director said he interviewed the staff involved with Patient #1's care at the time of the alleged assault, but not until 12 days later on 11/30/07 and 12/5/07. The Director stated that Patient #1's wound might have been self inflicted, but he wasn't sure. The Director stated he notified the police on 12/4/07, and was given an assigned case number by the local police agency. This was 16 days after the alleged assault. The Director said family members were not immediately made aware of the bruise. He said he did discuss the bruise with a family member on 11/19/07. The Director stated he was aware of his reporting responsibilities to the police, but failed to do so. He stated that because of Patient #1's psychiatric presentation he did not know if the allegation statements were, "delusional or not."</p> <p>The discharge summary, dated 12/19/07 at 1655 hours, by Psychiatrist #1, documented Patient #1 had a "complication" which occurred on Saturday morning. The Psychiatrist documented she had a black eye. The psychiatrist documented Patient #1 received a black eye either from assault or fall. The psychiatrist documented that Patient #1 told him she was assaulted by a staff member, but would not tell the name of the staff member. The psychiatrist documented Patient #1 told him the staff member threatened her and hit her in the face.</p>		<p>Administration for notification and follow-up. This will start by 11/1/08, after staff has been in-serviced on the tool.</p> <ul style="list-style-type: none"> A treatment team meeting will be convened within 24 hours after an allegation has been identified. The patient will be placed on a 1:1 until the investigation concludes there is not a patient safety risk. Started: 10/1/08. A log will be maintained by the Program Director of the NeuroPsychiatric Unit of the treatment meetings convened. 		

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	<p>Continued From page 5</p> <p>Member #2 is listed as the emergency contact for Patient #1. Family Member #2 did not want to report her concern about the facility's lack of regard and welfare for Patient #1 to authorities, until Patient #1 was "out of the facility." When Family Member #2 asked Patient #1 about the bruise to her face, Patient #1 replied that she was slapped across her face and then a man took her fist, balled it up, and put it in her mouth. Family Member #2 stated she visited Patient #1 every two days. She inquired to the staff about the facial injury and staff members said they did not know what happened. She said they told her they thought she had fallen down.</p> <p>On 1/30/08 at 0700 hours, interviews with staff members caring for Patient #1 on 11/17/07 (night shift), prior to discovery of the bruise to the face, were conducted. RN #1 stated that Patient #1 was cared for by him and CNA #1. He stated Patient #1 was difficult to manage. She refused medication, spitting them out, verbally abusive, and at no time was he aware of a wound to her face. He stated the bruise was reported to him when he returned to work the following day. He said he heard she was reporting that she was assaulted by a care giver. He stated he took photographs of the bruise on 11/18/07.</p> <p>CNA #1 stated she took care of Patient #1 on the night prior to discovery of the bruise. She stated Patient #1 had episodic vomiting and kicked her blanket, thrashing about in bed. CNA 1 stated that Patient 1 was trying to hit her. CNA #1 said Patient #1 kept saying, "You're hurting me, you're</p>			

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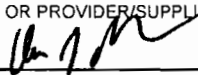
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