

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/24/2015
NAME OF PROVIDER OR SUPPLIER  California Pacific Medical Center – St. Luke’s Campus Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 3555 Cesar Chavez, San Francisco, CA 94110-4403 SAN FRANCISCO 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: CA00439028, CA00438717 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID #26616, 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 &amp; Safety Code 1280.3(b)(1) (b) Except as provided in subdivision (c), for a violation of this chapter or the rules and regulations promulgated thereunder that does not constitute a violation of subdivision (a), the department may assess an administrative penalty in an amount of up to twenty-five thousand dollars (\$25,000) per violation. This subdivision shall also apply to violation of regulations set forth in Article 3 (commencing with Section 127400) of Chapter 2 of Part 2 of Division 107 or the rules and regulations promulgated thereunder.</p> <p>The department shall promulgate regulations establishing the criteria to assess an administrative penalty against a health facility licensed pursuant</p>		<p>Please note: The following constitutes California Pacific Medical Center (CPMC) – St. Luke’s Campus’ credible evidence of correction of the alleged deficiencies cited by the California Department of Public Health in the Statement of Deficiencies Form CMS-2567 dated 9/24/2015. Preparation and/or execution of this credible evidence submission does not constitute admission of agreement by the provider of the truth of facts alleged or the conclusions set forth in the Statement of deficiencies.</p> <p>The Statement of Deficiencies form 2567 was received in this office on December 8, 2016.</p> <p>Corrective actions and associated monitoring plans begin on page 2.</p>	

Event ID:MSA311

12/5/2016

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LABORATORY DIRECTOR'S OR SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Helen Carey R</i>	TITLE Director, Risk Management	(X6) DATE 12/19/2016
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By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 13. 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.

State-2567

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*1/3/17 POC accepted - Dgundan HFEM 1*

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	<p>to subdivisions (a), (b), or (f) of Section 1250. The criteria shall include, but need not be limited to, the following:</p> <p>(1) The patient's physical and mental condition.</p> <p>Health &amp; Safety Code 1279.1(b)(5)(D) (b) For purposes of this section, "adverse event" includes any of the following: (5) Environmental events, including the following: (D) A patient death associated with a fall while being cared for in a health facility.</p> <p>T22 DIV5 CH1 ART3-70213(a) 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> <p>T22 DIV 5 CH1 ART3-70215(b) Planning and Implementing Patient Care (b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission.</p> <p>This RULE is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to:</p>		<p>T22 DIV 5 CH1 ART3- 70215(b)</p> <p><b>Corrective Actions:</b></p> <p>The telemetry unit nursing staff received education regarding the required elements of the post fall management policy and algorithm.</p> <p>Large posters of the post fall algorithm are posted at the nursing stations at the St. Luke's Campus.</p> <p><b>Monitoring Plan:</b></p> <p>Nursing education is validated by nursing staff signatures attesting to the Patient Safety Alert for post-fall management and successfully completing the post test.</p> <p>Monitoring results were reported to Executive Leadership.</p> <p><b>Responsible Persons:</b></p> <p>Director of Nursing, St. Luke's Campus</p>	<p>5/10/2015</p> <p>5/30/2015</p>

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EXCERPT FROM HEALTH

DEC 22 2016

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	<p>10. Assess Patient A per facility's policy after an unwitnessed fall; and</p> <p>2. Ensure Registered Nurses (RN) advocated for the patient to be seen by a physician for evaluation and for an urgent CT (computed tomography) scan per facility's policy.</p> <p>These failures constituted an immediate jeopardy which placed the health and safety of Patient A at risk when the staff failed to assess per the hospital's policy Patient A after an unwitnessed fall, that resulted in delayed recognition and treatment of the subdural hematoma (blood clot on the surface of the brain). Patient A had brain surgery, had complications after the surgery and died on 4/23/15.</p> <p>Findings:</p> <p>Patient A was admitted to the Telemetry (cardiac monitoring) unit on 4/7/15. The 4/8/15 physician Progress Notes indicated diagnoses including COPD (Chronic Obstructive Pulmonary Disease – progressive lung disease that makes it hard to breathe), benign paroxysmal positional vertigo (dizziness) and atrial fibrillation (abnormal heart rhythm characterized by rapid and irregular heart beat). Patient A's 4/7/15 nursing assessment indicated high risk for falls with a score of 17.</p> <p>The facility's Fall Prevention and Fall Management policy and procedures (P&amp;P), dated 4/14, indicated, "Implement High Falls Risk for a score of 10 (ten) or greater." According to the P&amp;P, the Neuro Checks are performed per Glasgow Coma</p>		<p>Cont.</p> <p><b>Corrective Action:</b></p> <p>The Nursing manager / supervisor must be notified when a patient fall has occurred. This notification is made to ensure the policy is adhered to.</p> <p><b>Monitoring Plan:</b></p> <p>All reports of patient falls will be reviewed to confirm the post-fall policy has been followed.</p> <p><b>Responsible Persons:</b></p> <p>Clinical Nurse Manager Risk Manager</p> <p><b>Corrective Action:</b></p> <p>Attending Internal Medicine physicians will be informed of the required physician actions and orders in the post-fall management policy.</p> <p><b>Monitoring Plan:</b></p> <p>Physician orders will be in compliance with the fall management policy. Compliance is measured through chart audits and post-fall huddle report forms.</p> <p><b>Responsible Persons:</b></p> <p>Chair of Medicine, St. Luke's Campus Risk Manager</p>	<p>5/10/2015</p> <p>5/10/2015 and for the next 30, 60, 90 days.</p> <p>4/30/2015</p> <p>5/10/2015 and for the next 30, 60, 90 days.</p>

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	<p>Scale or GCS - an assessment of consciousness in patients with head injuries which included eye opening, verbal and motor response. The P&amp;P included eyes evaluation for pupil size, reactivity and vision. A score of 15 was indicative of patient was alert, score of seven (7) or less was considered as comatose and score of three (3) was considered the patient was in deep coma.... The P&amp;P also indicated, "HEAD CT and NEURO CHECKS are indicated for patients who meet the criteria listed below:...Are on anticoagulant medication... The head CT is ordered by the MD and done as soon as after the incident as possible. The MD can order the CT urgent or Stat (now) if indicated....NEURO CHECKS are performed every 30 minutes x 4 (four times) then every hour x 4 until stable, and then per physician order if patient: a. Has a fall that is not witnessed, or b. Meets any of the criteria listed under Head CT indications... Appendix C: Algorithm for Post Fall Management - NO INJURY =&gt; UNWITNESSED FALL =&gt; C. PATIENTS MUST BE SEEN BY MD FOR ANY OF THE BELOW: ...Patient on Anti-coagulant... All unwitnessed falls..."</p> <p>Review of Patient A's Medication Administration Record indicated, on 4/8/15 at 12:29 AM, Patient A was administered apixaban (an anticoagulant - medication to prevent blood clots, prescribed for patients with atrial fibrillation) 5 mg. (milligrams); and at 10:59 AM, apixaban 5 mg. tablet and aspirin (medication to prevent blood clot) 81 mg. tablet were administered.</p> <p>According to lexicomp online (drug information</p>				

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	<p>website), apixaban and aspirin impede clot formation in the blood. Bleeding risk was increased in patients who received concomitant (drugs given at the same time) apixaban and aspirin therapy. For apixaban, serious potentially fatal bleeding may occur.</p> <p>Review of Patient A's medical record dated 4/8/15 indicated the following:</p> <ol style="list-style-type: none"> <li>At 11:30 AM, the nurse's Care Team Note indicated, Patient A was found lying on the floor on her right side. RN 1 documented, "States she (Patient A) felt dizzy after using the BC (bedside commode), claims she did not fall...no external physical injury, no complain of pain. Attending MD (physician) was notified."</li> <li>At 12:00 PM, RN 1 received a verbal order from Physician 1 to do "every six (6) hours neurological check." There was no documentation RN 1 questioned the physician's order, that it was not according to the facility's Fall P&amp;P of "every 30 minutes x 4 (four times) then every hour x 4 until stable, and then per physician order..." There was no documentation RN 1 advocated for Patient A to be seen by the physician for evaluation and for an urgent CT scan after the unwitnessed fall, per facility's Fall P&amp;P when a patient was on an anticoagulant [aspirin and apixaban].</li> <li>At 12:00 PM, RN 1 did the first neuro check which indicated, Patient A opened eye spontaneously, alert and oriented, followed verbal commands, and pupils equal round reactive to light</li> </ol>			

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	<p>and accommodation (PERRLA - an eye exam to check the brain function). There was no documentation of assessment for vision.</p> <p>4. At 12:30 PM, 1:00 PM and 1:30 PM, there was no documentation of a neuro check done by the licensed nurse or physician. The facility's Fall P&amp;P indicated a neuro check should have been done every 30 minutes for four (4) times after the fall.</p> <p>5. At 2:30 PM, (3 hours after the fall), licensed nurse's should have begun hourly neuro check per facility's Fall P&amp;P, however, the Neuro Check sheet indicated, there was no neuro check done.</p> <p>6. At 3:31 PM (4 hours after the fall), RN 2 did a Neuro Check which indicated, Patient A was alert, followed simple commands and pupils equal round reactive to light and accommodation (PERRLA - an eye exam to check the brain function and vision), GCS score was 15. There was no documentation of assessment for vision.</p> <p>7. At 4:00 PM (4 1/2 hours after the fall) - RN 2 documented on the nurse's notes, "Awakened pt (patient) and told her I'm (RN 2) going to give the lasix (medication which increases production of urine)... pt acknowledged and went back to sleep..."</p> <p>8. At 4:30 PM (5 hours after the fall), a third hourly nurse's neuro check was supposed to be done but there was no documentation this was done by RN 2.</p>				

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	<p>There was no documentation in the medical record RN 2 questioned Physician 1's order of "every 6 hours neurological check", which was not according to facility's Fall P&amp;P. There was no documentation in the medical record RN 2 advocated for Patient A to be seen by the physician for evaluation and for an urgent CT scan after the unwitnessed fall, per facility's Fall P&amp;P, when a patient was on an anticoagulant [aspirin and apixaban].</p> <p>9. At 5:20 PM, RN 2 documented on the nurse's i notes, "Tried to awaken the pt but unresponsive... No response on sternal (chest bone) rub and i voice.... Rapid response called... will tx (transfer) patient to ICU (intensive care unit)."</p> <p>10. At 5:40 PM (6 hours after the fall) - RN 2 documented a neuro check which indicated, Patient A was lethargic (inactive).</p> <p>11. At 6:47 PM (7 hours after the fall), CT scan, indicated, "Acute right sided subdural hemorrhage (bleeding on the surface of the brain) with resultant significant mass effect and 15 mm (millimeter) right to left midline shift (brain shifts position past its center line indicative of increased pressure inside the skull which could be fatal because it can crush brain tissue and restrict blood supply to the brain)."</p> <p>12. At 7:00 PM (7 112 hour after the fall), the nurse's neuro check sheet, indicated, Patient A had a GCS score of three (3), indicative of a deep coma, and her pupils were fixed (indicative of brain injury).</p>			

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	<p>Review of the CT scan, dated 4/9/15 at 9:17 AM, indicated, "The large right-sided subdural hematoma is again identified. It has not significantly enlarged since the previous study of   approximately 12 hours earlier....relatively stable large right frontotemporal parietal subdural hematoma with 12 mm midline shift... increasing ventricular dilatation compatible with obstructive hydrocephalus (build-up of fluids in the skull causing the brain to swell). The right ventricle however is compressed by the mass effect."</p> <p>Review of the Operative Report dated 4/9/15 at 1:48 PM, indicated, "This patient status post trauma yesterday while under anticoagulant therapy for atrial fibrillation with a direct thrombin inhibitor, is having craniotomy (a section of the skull, called a bone flap, is removed to access the brain) today, 24 hours after the last dose of the direct thrombin inhibitor to evacuate the subdural hematoma."</p> <p>According to uptodate.com, an article entitled Subdural hematoma in adults: Prognosis and ; management, indicated, "For patients with an acute SDH (acute subdural hematoma), clinical status and head CT findings can be used to select those who require emergent surgical decompression from those in whom initial medical management may be appropriate...we recommend urgent (within two to four hours) surgical hematoma evacuation for patients with acute SDH and the potential for recovery who are admitted with signs attributable to brain herniation or elevated intracranial pressure, such as asymmetric or fixed and dilated pupils. In</p>				

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	<p>addition, we recommend urgent surgical hematoma evacuation for patients with acute SDH, with or without coma, who have evidence of neurologic deterioration since the time of injury, and we suggest urgent surgical hematoma evacuation for patients with clot thickness &gt; 10 mm or midline shift &gt;5 mm on initial brain scan."</p> <p>Review of the 4/9/15 Physician Progress Notes indicated Patient A had decompressive craniotomy (surgical removal of the part of skull bone to expose the brain) and hematoma (blood clot) evacuation. On 4/11/15, Physician Notes indicated, "The patient (Patient A) remains neurologically critically ill requiring involvement of ...pulm (pulmonary) crit (critical) care services."</p> <p>Review of the physician Interim Summary, dated 4/19/15 at 10:29 AM, indicated, "On 4/12/15, patient was diuresed (increased in the production of urine by kidneys) and transfused one unit PRBC (packed red blood cells). She (Patient A) suffered from severe encephalopathy (general term which means brain disease, damage or malfunction) and remained intubated (insertion of a breathing tube in the airway for mechanical ventilation) until 4/16 when she was extubated... Patient (Patient A) was remained on NG (nasogastric - tube inserted through the nose to stomach) tube feeding. Palliative care team involved to discuss with family about goals of care and she was made DNAR (do not attempt to resuscitate). She (Patient A) became obtunded (altered level of consciousness) on 4/19 morning and ABG (arterial blood gas) showed severe acidosis (too much acid in the</p>			

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	<p>blood)... She was placed on Bipap (machine that helps patient breathe more easily). Family considering comfort care."</p> <p>Review of the 4/23/15 Hospitalist Discharge Summary indicated, "Patient (Patient A) presented...with atrial fibrillation. She was placed on anticoagulation with Eliquis (apixaban) and later sustained a mechanical fall which was unwitnessed but without apparent injury. She later became unresponsive and a CT scan revealed a large subdural hematoma.... she was operated on 4/9/15 to allow some resolution of the effects of Eliquis... Her course was complicated by cerebral edema (swelling of the brain), hydrocephalus (abnormal accumulation of fluids in the brain), and development of a left basal ganglion/thalamic stroke (poor blood flow to the brain causing brain cells death)... Discharge Condition: Expired."</p> <p>Review of the 4/24/15 Medical Examiner Report indicated, "The decedent sustained a fall from a standing height resulting in a subdural hematoma ultimately resulting in her death."</p> <p>During an interview on 4/22/15 at 10:36 AM, the Director of Risk Management (DRM) stated Patient A was on Eliquis (apixaban) and had an unwitnessed fall when the patient was found on the floor on 4/8/15 at 11:30 AM. The DRM stated, the facility's Fall P&amp;P Algorithm should be followed after an unwitnessed fall, and the licensed nurse should notify the physician, the physician must see the patient and order a CT scan when patient was on an anticoagulant. The DRM stated, the licensed</p>				

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	<p>nurse must perform neuro checks (GCS) every 30 minutes four times and every hour until the patient was stable. When asked what should the licensed nurse do if the physician's order was not according ] to the facility's policy, DRM stated, "Licensed nurses should tell the physician that the order was not according to the hospital policy."</p> <p>During an interview on 4/24/15 at 2:35 PM, RN 1 stated on 4/8/15 at 11:30 AM, Patient A was found lying on the floor and patient said she felt dizzy. RN 1 stated Patient A had no physical injury, no complaint of pain and the neurological observations (GCS) were within defined limits or normal. RN 1 stated Physician 1 was notified of the fall and Physician 1 ordered neurological checks every six (6) hours for 24 hours. When asked why a more frequent GCS like every 30 minutes was not done as indicated on the Fall P&amp;P, RN 1 stated, "Because Physician 1 ordered to do neuro obs (neurological observation or GCS) every six (6) hours, and I relied on his order." RN 1 stated they ; did not have post fall huddle (meeting with interdisciplinary team [IDT] like licensed nurses, care assistant physicians etc.) regarding Patient A's unwitnessed fall, but he (RN 1) filled out the Post Fall Huddle form. When asked if he (RN 1) was familiar with Fall P&amp;P, RN 1 stated, "I'm not ! quite familiar with the fall policy."</p> <p>During an interview on 4/28/15 at 4:15 PM, RN 2 stated, on change of shift report, RN 1 reported Patient A had an unwitnessed fall, was on apixaban, physician was notified but CT scan was not ordered, Post Fall Huddle form was filled out,</p>			

Event ID:MSA311

12/5/2016

4:06:32PM

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/24/2015
NAME OF PROVIDER OR SUPPLIER  California Pacific Medical Center – St. Luke’s Campus Hospital			STREET ADDRESS, CITY, STATE, ZIP CODE 3555 Cesar Chavez, San Francisco, CA 94110-4403 SAN FRANCISCO COUNTY		
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	<p>and the GCS score was 15 (meaning fully alert and oriented). When asked what he did when he noticed RN 1 and Physician 1 did not follow the Fall P&amp;P like every 30 minutes GCS, CT scan for patient on anticoagulant, and patient to be seen by a physician if it was an unwitnessed fall even if there was no injury, RN 2 stated, he should have called the physician again so CT scan could be ordered and notify the charge nurse that the Fall P&amp;P was not followed.</p> <p>During an interview on 4/28/15 at 4:45 PM, Physician 1 stated RN 1 notified him that Patient A was found lying on the floor but patient denied falling, there was no complaint of pain, no physical injury and vital signs (blood pressure, temperature etc.) was at baseline (normal). Physician 1 stated he gave an order to RN 1 to monitor Patient A closely for two hours then every six hours. When asked if his order was according to the hospital's Fall P&amp;P, Physician 1 stated, "I don't know any fall protocol or was I notified of such protocol." Physician 1 stated he prescribed apixaban for Patient A's new-onset of atrial fibrillation but did not order CT scan because of what RN 1 told him, that Patient A was adamant she did not fall. Physician 1 stated he did not see Patient A after the unwitnessed fall because he was at the clinic seeing other patients and have already seen Patient A in the morning of 4/8/15 (before the fall).</p> <p>Review of the facility's Fall Prevention and Fall Management P&amp;P revised 4/14, indicated, "Post Fall Huddle: 1. Called by the charge nurse with nursing supervisor within 60 minutes. 2. Attendees</p>				

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	<p>include Registered Nurse, PCA (Patient Care Assistant), MD, Nurse Manager...3. The details of the event are discussed, defects are identified, and additional interventions implemented...."</p> <p>The facility's failure to ensure Patient A was assessed per facility's policy after an unwitnessed fall, ensure Registered Nurses advocated for the patient to be seen by a physician for evaluation and request for an urgent CT scan, and implement the facility's Fall Prevention and Fall Management policy and procedure, are deficiencies that had caused harm to the patient.</p> <p>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).</p>				

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