

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/09/2016
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NAME OF PROVIDER OR SUPPLIER California Pacific Medical Center – Davies Campus Hospital	STREET ADDRESS, CITY, STATE, ZIP CODE 601 Duboce Ave, San Francisco, CA 94117-3389 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: CA00500940 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID #2162, 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 Section 1279.1 (c)</p> <p>"The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made."</p> <p>The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made.</p> <p>Health and Safety Code 1279.1 (b) (b) For purposes of this section, "adverse event" includes any of the following:</p> <p>Health and Safety Code 1279.1 (b)(5)(D) (b) For purposes of this section, "adverse event"</p>		<p>Please note:</p> <p>The following constitutes California Pacific Medical Center (CPMC) Davies' 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 12/09/2016. 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 May 25, 2017</p> <p>Corrective actions and associated monitoring plans begin on page 2</p> <p style="text-align: center;">CDPH L&C JUN 09 2017 SAN FRANCISCO DO</p>	

Event ID:O5C311

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

Heather Correy, RD

TITLE

Director, Risk Management

(X6) DATE

6/5/2017

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 10

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.

6/8/17 POC accepted Jennifer HFEM

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	<p>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 ART3-70215(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: Based on interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Assess Patient 1 for signs and symptoms of delirium, and advocated for the patient to be seen by a physician for evaluation and treatment. 2. Ensure adequate nursing supervision and fall prevention measures were provided to Patient 1 per facility's policy and procedure (P&P). <p>Patient 1 showed signs and symptoms of delirium, was high risk for falls, had an order for sitter, however, Patient 1 was left alone in the room where she stood up and fell striking her face on the floor on 5/1/16. Patient 1 sustained a subdural hematoma (bleeding within the area between the brain and the tissues that cover the brain). Patient 1 declined after the fall and died on 8/30/16.</p>		<p>T22 DIV5 CH1 ART3-70215(b) Planning and Implementing Patient Care Corrective Actions:</p> <ol style="list-style-type: none"> 1. Focused education on "Managing Patients with Delirium" was presented to the nursing staff of the Acute Rehab Units, 1 North and 2 North. The education was provided by the Nurse Practitioner in the Hospital Elder Life Program. 2. Patient safety, changes in condition, behavioral issues and challenges are all addressed in interdisciplinary team rounds. 3. For Acute Rehab patients on fall precautions, nursing will review the patient care plans to ensure the adequate fall prevention interventions are included in the plan of care <p>Monitoring Plan:</p> <ol style="list-style-type: none"> 1. Nursing will audit Acute Rehab patient records for the development of a neurobehavioral plan for patients identified as agitated and/or confused. Audits will also include Psychiatric Consultation for patients with a Delirium diagnosis. 	<p>June 6,7,8, 2016</p> <p>Current practice</p> <p>June 12, 2017</p> <p>June 12, 2017 and ongoing for 90 days</p>

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	<p>Delirium is a condition that features rapidly changing mental states. It causes confusion and changes in behavior. Besides falling in and out of consciousness, there may be problems with attention and awareness, thinking and memory, emotion, muscle control, sleeping and walking. Causes of delirium include medications, serious illness or infections and severe pain.</p> <p>Findings:</p> <p>Review of the medical record indicated Patient 1 was admitted to the facility on 4/19/16 with worsening right sided weakness due to stroke (poor blood flow to the brain causing brain cell death). Her 4/19/16 Fall Risk Indicators indicated a score of 15 (according to facility's Fall Prevention and Fall Management - Initiate High falls risk Interventions for a Score of 10 or above.) The physician had an order for SITTER on 4/19/16.</p> <p>Review of the 4/19/16 Fall Care Plan indicated, "1. Monitor/Assist with Self Care: ...Assess assistance level required for safe/effective self care. Encourage functional activity performance with appropriate level of assistance based upon level of ability."</p> <p>Review of the 5/1/16 Physical Therapy Treatment note, indicated, "Precautions/Limitations: fall precautions." It also indicated Patient 1 had gait training for 30 minutes, safe bed mobility and transfers with FWW (four-wheel walker)."</p>		<p>Monitoring Plan cont.</p> <p>2. Nursing will audit Acute Rehab patient records to ensure adequate fall prevention interventions are initiated and implemented in the plan of care.</p> <p>The sample size is a minimum of 15 patient records per week.</p> <p>Audit results will be tabulated and reported at 30, 60, and 90 days.</p> <p>The monitoring results will be reported to the Nursing Quality Committee and the Quality Improvement Committee.</p> <p>Responsible Persons:</p> <p>Clinical Manager, 1N and 2N Director of Nursing, Davies Campus</p>	<p>June 12, 2017 and ongoing for 90 days</p>

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	<p>Review of the 5/1/16 PM (Afternoon) Nursing Assignment Sheet indicated, "Patient 1-1:1 sitter (shadower)." The assigned sitter/shadower was CNA1.</p> <p>Review of the Acute Rehab Patient Behavior Log, dated 5/1/16, evening shift (3 PM to 11 PM), indicated, "She (Patient 1) is not cooperative since 1530 (3:30 PM) to 10:00 PM. She is combative. She is very compulsive." The Log indicated, "DISTANCE FROM THE PATIENT- Doorway, In plain sight", which meant the shadower (CNA 1) was in the doorway where she could plainly see Patient 1.</p> <p>Review of the Care Plan Notes on 5/1/16 at 2:51 PM , indicated, "Patient 1 is alert and oriented x2 (the person knows who she is and where she is but not the time and event) with forgetfulness. With sitter by the doorway in view of the patient. No unsafe behavior reported... Min (minimum) to mod (moderate) assist stand step with transfer using FvWV. Assisted by therapist to toilet and voided and also had BMx1 (bowel movement). Bladder scanned at 1330 (1:30 PM) and noted 291 ml. (milliliters) in her bladder."</p> <p>Review of the 5/1/16 2300 (11:00 PM) Hospitalist Cross-cover Note, indicated, "Called at 2138 (9:38 PM) by nurse to see pt (Patient 1) for fall. Pt apparently been very impulsive and aggressive today. A sitter was ordered and present. Pt reportedly got out of the wheelchair in her room and fell forward striking her face on the floor. Unclear if sitter was still in the room when she fell or had gone into the next room to get assistance from the nurse</p>			

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	<p>in getting pt back to bed. No loss of consciousness. Pt seen immediately and assessed. Pt denied any pain or headache. On exam: Small ecchymosis/hematoma (bruise) of right lower lip. Small amount of blood in the mouth. Small 1 (one) cm (centimeter) laceration on the inside of the lower lip on the right side. Palpation of facial bones does not show any area of tenderness or deformity. The c-spine (neck bone) is without tenderness and has full range of motion without pain or crepitus (grating sound). CT (Computed Tomography) head and facial bones ordered stat. CT head read by radiologist as showing a small area of traumatic subarachnoid hemorrhage in the distribution of the LMCA (left middle cerebral artery). No facial fractures reported. Imp (Impression): 1. Small subarachnoid hemorrhage, likely traumatic. Will transfer pt (Patient 1) to our TICU (Trauma Intensive Care Unit) for closer monitoring. Pt noted to be on aspirin, Plavix and subcutaneous heparin (medications to prevent blood clot with side effects of bleeding). Will hold all three..."</p> <p>Review of the Care Plan Notes on 5/2/16 at 12:50 AM, indicated, "Pt was very confused, very agitated, non-compliant, combative, push away staff, scratched the sitter... Daughter was in the room then left at 1900 (7 PM). Sitter was observing patient, and when approached to pt, she (Patient 1) pushed away, RN spent a lot of time in the room c (with) pt. Keep removing safety belt around her. At 2145 (9:45 PM) sitter reported that pt got up from W/C (wheelchair) and fell. Pt was found lying on the floor facing down. Pt was assessed, denied pain, put to bed. Called HO (House Officer/physician)..."</p>				

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	<p>Family member called and notified."</p> <p>Review of the 5/3/16 Consult-Liaison Psychiatry - Initial Note, indicated, "IMPRESSION: Delirium with behavioral disturbance... with no prior psychiatric history. Patient has history of embolic stroke, has been confused, recently fell causing small subarachnoid hemorrhage. Patient also had UTI (urinary tract infection). Patient was recently started on Zyprexa; as patient's behavior has improved, and daughter strongly advocates for patient to continue Zyprexa due to agitation, will continue scheduled and PRN (when necessary) dosing.... Diagnosis: Delirium.</p> <p>Review of the 8/26/16 Physical Therapy Discharge Summary indicated, "She (Patient 1) was admitted to ARU (Acute Rehab Unit), but transferred to TICU following a fall on 5/1/16 and CT head revealing small traumatic SAH (subdural hematoma)... Pt progressive function and cognitive decline and impaired alertness level since return from TICU in 5/1/16. Pt requires total assistance for all care and unable to actively participate in therapy session.... Family has decided to place pt on comfort care."</p> <p>Review of the 8/30 Death Summary, indicated, "Review of care reveals medical and functional consensus of neurology, Palliative Care, hospitalist... that the patient is unlikely to come out of this prolonged quiet delirium. Further, if she were emerge this prolonged delirium, it is doubtful that it would be meaningful improvement. It has been several months since her condition approximated a reasonable quality of life, so pursuing a higher level</p>			

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	<p>of consciousness... would not bring her to a happy state with a good quality of life... Patient's course has been complicated by delirium, recurrent urinary tract infection, UTIs not helped by medication management. Per the patient's medical team, the patient has moved from being a state of hyperactive delirium (restlessness, agitation, rapid mood changes or hallucinations) to profound hypoactive delirium (inactivity or reduced motor activity, sluggishness, abnormal drowsiness or seeming in daze). While she opens her eyes, she does not follow commands or respond to any questions. Patient has also been seen by Psychiatry and several efforts have been optimize her mental status. She is,dependent for all activities. She eats intermittently and very often pockets food in her mouth. The patient's prognosis is poor given prolonged hypoactive delirium is a known risk for increased mortality." The Death Summary indicated, Patient 1 passed on 8/30/16.</p> <p>During an interview on 9/27/16 at 4:15 PM, the complainant stated there was huge breakdown in the communication in the facility. The complainant stated she was told Patient 1 had a one to one sitter, however, CNA 1 was sitting outside between two rooms, watching two patients. The complainant stated she told the nurse to change the sitter because CNA 1 was not compatible with Patient 1 because the patient got more upset when CNA 1 was in the room, but this was not done. The complainant stated CNA 1 had no training on how to handle Patient 1's behavior. The complainant stated after Patient 1's daughter left the facility, she received a phone call saying Patient 1 fell and was</p>			

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	<p>transferred to TICU. The complainant stated when she asked the facility how Patient 1 fell, the facility staff told her, Patient 1 fell because CNA 1 looked away. The complainant stated the facility could not confirm with her if the fall was witnessed or unwitnessed. The complainant stated Patient 1 was admitted for rehabilitation after the stroke, however, after the fall, Patient 1 became immobile and her mental status declined. The complainant stated Patient 1 passed away on 8/30/16.</p> <p>During an interview on 10/24/16 at 9:43 AM, CNA 1 stated she was told by the nurse she would be a shadower (sitter) to a Patient 1 who was impulsive and combative. CNA 1 stated she got a hand over from the morning shift CNA who was shadowing two patients. CNA 1 was asked if she knew she would be a one to one sitter for Patient 1, CNA 1 stated the nurse did not talk to her about her assignment so she was shadowing two patients. CNA 1 stated she was sitting outside Patient 1's room while the daughter was inside and was also monitoring another patient in the adjacent room. CNA 1 stated when Patient 1's daughter left, she went inside the room and tried to put back the lap belt (safety belt of the wheelchair) because Patient 1 was trying to stand up. CNA 1 stated Patient 1 scratched and grabbed her. CNA 1 stated she pressed the call light but it was taking a long time for staff to answer so she stepped out of the room to go next door to call for the nurse. CNA 1 stated she stood between the two rooms while calling for the nurse and saw Patient 1 stood up and fell on her face. CNA 1 stated it was too late when she and the nurse stepped into the room because Patient 1 was</p>			

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	<p>already on the floor. When asked why she left Patient 1 at the critical point when patient was very aggressive and trying to stand up, CNA 1 said that she wanted to get help right away.</p> <p>During an interview on 10/24/16 at 10:00 AM, the Director of Risk Management (DRM) stated Patient 1 was not diagnosed with delirium by the physician. DRM stated the nurse should have assessed Patient 1's behavior and referred to the physician when Patient 1 was being combative and aggressive. DRM stated the sitter should not have left the room and should be at an arm's length distance from Patient 1 so she could reach the patient when she stands up.</p> <p>Review of the facility's Nursing Guidelines for Shadowing Protocol, revised 05/09/14 indicated, "The purpose of the Shadowing Protocol is to provide 1:1 supervision to designated patients to prevent harm and/or injury.... 1. The RN (Registered Nurse) is responsible for the following steps every shift (as directed by the Charge Nurse): 1.1 Educate the shadower of the primary problems for this patient, including the types of unsafe behaviors likely exhibited, and the types of interventions that are likely to be most effective. Refer to previous Patient Behavior Logs for specific examples 1.2 Throughout the shift, the RN will review the Patient Behavior Log. If incomplete, additional information should be obtained from the shadower and added to the log. 1.3 Demonstrate to the shadower how to complete the Patient Behavior Log and set clear expectations for the quantity and quality of information to be documented. It is the RNs</p>				

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	<p>responsibility that these logs are completed and provide useful information. 1.4 Target behaviors must be written down by RN based on Neurobehavioral plan 2. The RN will instruct the shadower to monitor the patient from one of the following (RN will select appropriate selection based on Neurobehavioral plan): 2.1 At the bedside (at arm length). 2.2 At the doorway (in plain sight). 2.3 In the doorway, SHARED (in plain sight) 2.4 In the hallway (out of view, pt viewable)....4. The RN should also observe the shadower's ability to prevent harm or injury and compliance with expectations."</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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