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
	050115	A. BUILDING _____ B. WING	12/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOMAR HEALTH DOWNTOWN CAMPUS	555 E Valley Pkwy, Escondido, CA 92025-3048 SAN DIEGO COUNTY

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CA DEPT OF PUBLIC HEALTH
DEC 26 2012
LICENSING & CERTIFICATION
SAN DIEGO NORTH DISTRICT OFFICE

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00284117 - Substantiated Representing the Department of Public Health: Surveyor ID # 22363, **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 1280.1(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. California Codes Health & Safety Code, Section 1279.1 (a) (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. California Codes Health & Safety Code, Section 1279.1 (b)(5)(D) (b) For purposes of this section, "adverse event"		**California Codes Health & Safety Code, Section1279.1 (a)** Substantial changes have been made to the reporting, investigation and follow-up process as follows. Procedures related to Adverse and Sentinel Events and Reporting requirements were revised and merged to create procedure 28172 Near Miss, Adverse and Sentinel Event Investigations and Follow-Up. This document identifies the actions required to complete investigations and includes; 1. Elements of how corrections will be accomplished. 2. Who is responsible for the corrections 3. A description of the monitoring process. 4. Instructions that insure follow up related to performance and adherence to process and procedure is reported through the Quality and Patient Safety Committee structure and to the Board of Directors. **Person Responsible**: Opal Reinbold, Chief Quality Officer **Addendum #1:** Procedure 28172; "Near Miss, Adverse and Sentinel Event Investigation and Follow-up"	**11.19.12**

Event ID: 51G011 12/10/2012 7:47:13AM

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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.

PHS 12/31/18

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	Continued From page 1 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. California Codes Health & Safety Code, Section 1279.1 (c) (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. 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. California Code of Regulations, Title 22, Chapter 1, §70215 Planning and Implementing Patient Care. (a) A registered nurse shall directly provide: (2) The planning, supervision, implementation, and evaluation of 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 limitation of their licensure, certification, level of validated competency, and/or regulation. The facility failed to provide implementation and evaluation of nursing care to Patient A following a **fall, with associated head injury, in the IMC** (Intermediate Care Unit). The fall resulted in bleeding in the brain, coma, eventual withdrawal of life support, and ultimately the death of Patient A. Patient A, a 64 year old male, was seen in the		Procedure 18244 "Standards of Patient Care for the Adult Inpatient" outlines the responsibility of the RN for assessment, planning, supervision, implementation and evaluation of care provided. The RN who involved in the care of this patient was counseled related to; 1. Failure to follow the Clinical Institute Withdrawal Assessment (CIWA) protocol 2. Failure to notify the MD for documented HR over 120 ppm 3. Failure to complete / document complete vital signs and assessment related to the HR 4. Failure to notify the physician of CIWA scores over 15 5. Initiation of O2 for saturations of 96% despite order to maintain oxygen saturations of 92% 6. Failure to call RRT when patient was found unresponsive 7. Importance of accurate documentation of care provided and adherence to physician orders. 8. Notification of the planned audit of 10 medical records for documentation. **Person Responsible**: Rae Anne Watson, RN Nursing Director **Addendum #2:** Procedure 18244; "Standards of Patient Care for the Adult Inpatient" **Addendum #3:** Staff Counseling Date 11.27.11	**11.27.11**

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	Continued From page 2 facility's Emergency Department (ED) on [redacted]11 at approximately 2:03p.m. According to the ED notes, Patient A presented with signs and symptoms that were consistent with an alcohol withdrawal syndrome. The notes indicated Patient A had a generalized tonic clonic seizure (generalized seizure affecting the entire brain), lasting approximately 2 minutes, while waiting for evaluation in the ED, and another seizure while still in the ED. Patient A's Significant Other reported multiple falls at home, and the ED physician noted Patient A had multiple resolving ecchymosis (bruising) on his arms and legs. The notes indicated Patient A's last alcoholic drink was the day prior, on [redacted]11.The ED physician ordered a CT (Computed Tomography) scan of the brain (imaging studies of the brain) for an altered level of consciousness, which was normal, according to the radiologists' report. Patient A was admitted to the IMC on the 7th floor, on [redacted]11 at approximately 8:00p.m., according to the nursing documentation. Patient A was placed in a room on the 7th floor, which was not visible from the nursing station. The admitting physician's history and physical (H&P) was reviewed on 12/7/11. According to the H&P, Patient A had new seizures related to alcohol withdrawal and a diagnosis of thrombocytopenia (an abnormally low platelet count. Platelets are what help the blood to clot). The physician ordered seizure and fall precautions, as well as CIWA (Clinical Institute Withdrawal Assessment) protocol.		Communication guidelines were established between the Administrative Supervisors and the Charge RNs related to identification of patients on CIWA for appropriate and safe patient room assignment. **Person Responsible:** Joy Gorzeman, Chief Nursing Officer	**1.31.12**

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	Continued From page 3 The CIWA protocol was reviewed with Administrative Staff on 1217/11. According to Administrative Staff, the facility utilized a CIWA protocol order set entitled, Alcohol Withdrawal Order Set. According to the order set, nursing staff were to: Assess and record the CIWA scores every four hours for a minimum of 13 total assessments (48 hours of initial assessment). Built into the order set are parameters for notification of the physician. According to the order set, the physician should be notified for: An elevated blood pressure (systolic over 160). A heart rate greater than 100 (in Patient A's case, the physician changed the parameter to be notified for a heart rate greater than 120). Another of the parameters for physician notification is a CIWA score greater than 15. According to Administrative Staff, the reason for notification of the physician of CIWA scores greater than 15 are because once a patient's score is greater than 15, it means, "The patient is too much to handle in IMC and needs to be transferred to ICU." Registered Nurse (RN) 2, the first nurse to care for Patient A on the day of admission at IMC and again the following day [redacted]11 and [redacted]11 from 7 p.m. to 7 a.m.), was interviewed on 12/7/11. According to RN 2, Patient A was "really confused" and "out of it." RN 2 recalled the patient was "impulsive" and		An audit of the documentation of CIWA patient assessments was performed on 100% of patients for a 6 month period. Follow-up education and possible staff counseling will be performed based on the audit outcomes. **Person Responsible;** Rae Anne Watson, RN, Nursing Director **Addendum #4:** Audit; CIWA Charge RNs and Unit Leadership review patient acuity and staffing at the beginning of each shift and PRN based on changes in unit census and patient acuity. Staffing maybe adjusted when appropriate. **Person Responsible**: Rae Anne Watson, Nursing Director Procedure 28112 "Admission and Level of Care Criteria" was revised to clarity the level of care for CIWA scores greater than 15. **Person Responsible:** Director of Critical Care **Addendum #5;** Procedure 28112 "Admission and Level of Care Criteria"	**12.18.12** **Ongoing** **6.28.12**

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	Continued From page 4 "wouldn't listen." RN 2 stated the patient was found out of bed in the bathroom holding his tab alarm. (Tab alarm is a device connected to the patient's clothing and to the bed, so that when the patient gets out of bed, the alarm becomes detached and emits a loud noise.) RN 2 stated that Patient A took the entire tab alarm unit with him, so that the alarm would not disconnect from his person and therefore, no alarm would sound. RN 2 stated he found Patient A with his legs up over the rails of the bed and found him several times trying to get out of the bed. RN 2 did not recall if the bed alarms were on (bed alarms sound when the patient gets out of bed). According to RN 2, he told the Charge Nurse (CN X) that Patient A should be on a one-to-one (1:1) status (one nurse or a sitter to one patient for constant observation). RN 2 stated he warned the oncoming nurse (RN 3) to keep an eye on Patient A. According to the clinical record, Patient A was not placed on a 1:1 statu. RN 3, the nurse caring for Patient A on [redacted]11 and [redacted]11 from 7:00a.m. to 7:00p.m., was interviewed on 11/10/11 and again on 1217/11. RN 3 stated that Patient A was "impulsive" and "would get out of bed" and "would not follow directions." The staff continually reminded Patient A to ask for help before getting out of bed, but he wouldn't. RN 3 recalled the bed alarms were not in use, but didn't know why. According to RN 3, she had just been in the room prior to Patient A falling, and told him to stay in bed.		The CIWA Institute Withdrawal Assessment, (Alcohol Withdrawal Order Set), was reviewed and reformatted to insure the criteria for physician notification was automatically initiated with the order set. **Person Responsible**: Joy Gorzeman, Chief Nursing Officer **Addendum #6:** Alcohol Withdrawal Order Set Procedure 28112 "Admission and Level of Care Criteria" was revised to clarify the level of care for CIWA scores greater than 15. **Person Responsible:** Director of Critical Care **Addendum #5:** procedure 28112' "Admission and Level of Care Criteria" Administrative Supervisors and Charge Staff have been provided education related to the revisions to procedure 28112 "Admission and Level of Care Criteria". **Person Responsible;** Rae Anne Watson, RN, Nursing Director **Addendum #7:** In-service; Read & Sign; procedure; 28112 "Admission and Level of Care Criteria"	**1.31.12** **6.28.12** **1.10.13**

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	Continued From page 5 A review of RN 3's documentation indicated one CIWA assessment was recorded on the morning of [redacted]11 at 8:00 a.m. The 12:00 p.m. and 4:00 p.m. CIWA assessments, prior to the fall, were not documented. RN 1, the nurse caring for Patient A on [redacted]1 from 7:00p.m. to 7:00a.m., was interviewed on 9/28/11 and 12n/11. RN 1 recalled Patient A had a tab alarm on, but no bed alarms. According to RN 1, just prior to the fall, Patient A demonstrated that he knew how to take the bed alarm *off* without the alarm sounding. RN 1 stated that Patient A said, "It's like the old car alarms," and proceeded to take the tab alarm off without it sounding and then put it back on. RN 1 stated he felt that Patient A should have been a 1:1. RN 1 stated that after Patient A demonstrated he could remove the alarm without it sounding, RN 1 and RN 3 continued on to the next room for bedside report. After they left the room, they heard a "thud" coming from Patient A's room. When they entered the room, Patient A was laying on the floor with his alarm in hand, still not sounding. Patient A was bleeding from his head and his nose. The nursing staff notified the on-call physician and received orders for a CT of the head. According to the radiologists report, the CT following the fall, showed a 2 cm acute right subdural hematoma (a collection of blood on the surface of the brain) and a 3 millimeter (mm) midline shift. (A shift of the brain, past its center line, is considered ominous, because it is commonly associated with a distortion of the brain stem that can cause serious		An audit of the documentation of CIWA patient assessments was performed on 100% of patients for a 6 month period. Follow-up education and possible staff counseling will be performed based on the audit outcomes. **Person Responsible;** Rae Anne Watson, RN, Nursing Director **Addendum #4:** Audit; CIWA Staff education was provided on signs and symptoms to report after fall and post fall documentation. **Person Responsible:** Rae Anne Watson, Nursing Director **Addendum #8:** Procedure 17662; "Fall Prevention and Management" **Addendum #9:** Procedure 24372; "Patient Hand Off Communication" **Addendum #10:** In-service; Alcohol Withdrawal and the CIWA-AR Tool, January 2012 **Addendum #11:** In-service; Versa Care Bed Exit Alarm Handout Daily rounds / audits are performed to insure that fall prevention measures are implemented. **Person Responsible:** Rae Anne Watson, RN **Addendum #12;** Audit; Fall Prevention Audit	**Ongoing** **2.1.12** **Ongoing**

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	Continued From page 6 dysfunction, evidenced by abnormal posturing and failure of the pupils to constrict in response to light definition per Wikipedia). The on-call physician (Physician Y) was notified of the results of the CT and ordered an assessment of neurological signs every hour for 6 hours and then every 4 hours. Following the fall, on the evening of [redacted]11, RN 1 documented CIWA assessments of 16 at 11:00 p.m. and 17 at 1:00 a.m. When questioned as to the significance of the elevated scores, RN 1 stated he knew he should have notified the physician, but he did not. At 3:36a.m., the Monitor Technician took a rhythm strip of Patient A's heart rate, as she noted an increased heart rate of 138. Again at 3:40 a.m., another strip was recorded due to a heart rate of greater than 154. Both strips were initialed by RN 1. RN 1 acknowledged his initials on the rhythm strips. RN 1 was questioned again as to why he didn't further assess Patient A or notify the physician, as the order was to notify the physician with a heart rate greater than 120. RN 1 acknowledged that with the elevated heart rate, further assessment was warranted, at least a full set of vital signs. He could not answer as to why he did not further assess Patient A. RN 1 acknowledged he did not notify the physician. RN 1 stated he thought Patient A was, "Just anxious." RN 1 was questioned as to why he medicated Patient A with Ativan for anxiety at 11:27 p.m. and 1:26 a.m., but didn't medicate Patient A for what RN 1 perceived as anxiety at 3:40 a.m. RN 1		The RN involved in the care of this patient was counseled related to; 9. Failure to follow the CIWA protocol 10. Failure to notify the MD for documented HR over 120 ppm 11. Failure to complete / document complete vital signs and assessment related to the HR 12. Failure to notify the physician of CIWA scores over 15 13. Initiation of O2 for saturations of 96% despite order to maintain oxygen saturations of 92% 14. Failure to call RRT when patient was found unresponsive 15. Importance of accurate documentation of care provided and adherence to physician orders. 16. Notification of the planned audit of 10 medical records for documentation. **Person Responsible**: Rae Anne Watson, RN Nursing Director **Addendum # 3:** Staff Counseling Date 11.27.11	**11.27.11**

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	Continued From page 7 stated, "I thought the anxiety would go away." RN 1 documented that he placed Patient A on oxygen at 4:00 a.m. According to the physician's orders, oxygen was to be used to maintain oxygen saturation levels to greater than 92%. RN 1 was asked why he found the need to place Patient A on oxygen at 4:00a.m., as the recorded oxygen saturation at that time was 96%. According to RN 1, he did not recall placing the patient on oxygen, although he did acknowledge documenting the administration of oxygen in Patient A's medical record at 4:00a.m. On [redacted]11 at 5:38a.m., approximately 10 hours following Patient A's fall, the phlebotomist (P1) came to the 7th floor for her routine blood draws. The phlebotomist (P1) was interviewed on 9/29/11 and 11/18/11. According to P1, she drew Patient A's blood the day before and he was "cranky and bitchy," but on the morning of the [redacted]11 she was unable to arouse him. She stated the patient seemed "drugged," and "snoring" in a "deep sleep." She said, "I couldn't wake him up." P1 recalled a nurse outside the room. P1 stated the nurse must have heard P1 yelling to wake the patient up and P1 said, "I assumed the nurse told someone." On the morning of [redacted]11 at 6:00a.m., RN 1 found Patient A unresponsive with a documented GCS (Glasgow Coma Scale) of 3, on a scale of 3-15. (Glasgow Coma Scale is a neurological scale that aims to give a reliable, objective way of recording the conscious state of a person for initial as well as subsequent assessments per Wikipedia). A score of three (3) on the GCS indicates the patient does		The phlebotomist was interviewed and her actions reviewed, during the case investigation by Laboratory Leadership. **Person Responsible:** Tim Barlow, Laboratory Manager	**11.30.12**

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	Continued From page 8 not open his eyes, is unable to make any verbal response or movement, and is in a deep unconsciousness. RN 1 stated Patient A had no voluntary movement, even to a deep sternal rub. (A deep sternal rub is a forceful rub to the sternum (breast bone) to elicit a response from the patient.) RN 1 stated Patient A's pupils were non-reactive (no reaction when a light is passed over the pupils). RN 1 stated he asked the Resource Nurse to validate his findings regarding the unconscious state of Patient A. According to RN 1, the Resource Nurse had the same observations. RN 1 stated he notified the on-call physician, Physician G, who was, "Sitting on the nurse's station." According to RN 1, he reported to Physician G that Patient A was "non-responsive," but Physician G stated he was off duty and told RN 1 to notify the oncoming physician, Physician L. RN 1 stated he then called Patient A's physician, Physician L, and waited for Physician L to arrive. When Physician L arrived, the physician initiated notification of the RRT (Rapid Response Team - a multidisciplinary team most frequently consisting of ICU (Intensive Care Unit) trained personnel, who are available 24 hours per day, 7 days per week for evaluation of patients who develop signs or symptoms of severe clinical deterioration). This was at 6:33a.m., 33 minutes after finding Patient A unresponsive, with a GCS of 3. RN 1 was questioned as to why he waited for the physician to call upon the RRT for help, but RN 1 had no answer. Physician G was interviewed by phone on 12/27/11 at 3:20p.m. According to Physician G, he was on shift from 10:00 p.m. to 6:00a.m. Physician G		The RN involved in the care of this patient was counseled related to; 1. Failure to follow the CIWA protocol 2. Failure to notify the MD for documented HR over 120 ppm 3. Failure to complete / document complete vital signs and assessment related to the HR 4. Failure to notify the physician of CIWA scores over 15 5. Initiation of O2 for saturations of 96% despite order to maintain oxygen saturations of 92% 6. Failure to call RRT when patient was found unresponsive 7. Importance of accurate documentation of care provided and adherence to physician orders. 8. Notification of the planned audit of 10 medical records for documentation. **Person Responsible:** Rae Anne Watson, RN, Nursing Director **Addendum #3:** Staff Counseling Date 11.27.11	**11.27.11**

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	Continued From page 9 stated Physician Y did not report off to him that Patient A had fallen during Physician to Physician report. According to Physician G, the first time he heard about a fall or any problem with Patient A was after Physician L came on shift at 6:00 a.m. Physician G said no one approached him at the nursing station regarding a patient in an unconscious state. Physician G stated he would not have told a nurse that he was "off duty" if there was an unconscious patient. He stated, "That's absurd." The Respiratory Therapist (RT 1), working on the 7th floor, was the first RT to respond. RT 1 had no recall of the event. The second RT to respond (RT 2) stated she took over for RT 1 who was "bagging" (hand-held device used to provide positive pressure ventilation to a patient who is not breathing or who is breathing inadequately) the patient. RT 2 stated Patient A was non-responsive, comatose, and had a large bulge on his head that was covered with a bandage. Shortly thereafter, Patient A was intubated (breathing tube inserted for mechanical ventilation) by the ED physician. Then the Rapid Response Team arrived and hooked Patient A up to the monitors. The RRT Nurse (RRT 3), that responded on [redacted]11 at 6:35a.m., was interviewed on 11/10/11. According to RRT 3, whenever she responds to calls, she brings along a monitor and she hooks the patients up to the monitor. At the end of the call, she prints out a strip. The strip records ongoing vital signs and oxygen saturations. She then places the strip onto the RRT sheet, which		Hand off communication between the off-going and on-coming physicians was referred to the Medical Staff Peer Review process. The Medical Staff Peer Review Committee meets under the leadership of the Chairperson who is a member of the medical staff. RN members of the Quality Department support the Medical Peer Review process by identification of cases for review, record review, investigation and attendance at the Peer Review Committee meetings. The discussions and recommendations of the Medical Peer Review Committee are confidential and protected under section 1157. **Person Responsible**: Opal Reinbold, CQO	**11.22.11**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050115	A. BUILDING _____ B. IMNG	12/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Continued From page 10 she is responsible for filling out. RRT 3 pointed out the area on the RRT sheet where she attaches the strip. There was no strip attached to the RRT sheet. She was unable to explain why the printed strip was missing. On 11/10/11 at 1:00 p.m., the Monitor Technician (MT) was interviewed regarding the recorded rhythm strips from [redacted]11 at 3:36a.m. and 3:40a.m. According to the MT, the facility documents rhythm strips in IMC every shift and with any changes in heart rhythm. The MT was questioned as to whether after discovering a heart rate of 154, a rhythm strip would be obtained to indicate a change back to normal. The MT stated she would have done another strip. The MT could not explain what happened to the rhythm strip indicating a change after the elevated heart rate of 154. In fact, there were no documented strips in Patient A's record from the 7th floor after the 3:40 a.m. strip, indicating a heart rate over 154. The third CT of Patient A's brain was done on [redacted]11 at 7:45a.m. The results were recorded as follows: "Marked increase in the right subdural hematoma...measures 14 mm, compared to approximately 7 mm on previous examination ([redacted]1 at 08:15p.m.). There was an increase in the size of the midline shift and left ventricle. Interval development of left ventricular and fourth ventricular bleeding. New 2.7 cm left intraparaenchymal bleeding centered over the left basal ganglia" (essentially indicating the bleeding had expanded into the tissue and ventricles of the brain).		Procedure #20571 "Rapid Response Team" was reviewed and revised. **Person Responsible**: Maria Sudak, RN, Nursing Director **Addendum #13**; Procedure #20571 "Rapid Response Team" The Rapid Response RN Team was provided education on revisions to procedure #20571. **Person Responsible**; Maria Sudak, RN, Nursing Director **Addendum #14:** In-service; Read & Sign; procedure 20571 "Rapid Response Team" Procedure 18787 "Remote Monitoring Room" was reviewed and audits related to documentation of rhythm strips by the Telemetry Technicians were implemented. **Person Responsible**; Maria Sudak , RN, Nursing Director **Addendum #15**; Procedure 18787 "Remote Monitoring Room **Addendum #16**: Audit; Rhythm Interpretation/Documentation Based on the results of the rhythm strip documentation audit, staff education and counseling will take place. **Person Responsible;** Maria Sudak, RN, Nursing Director	**1/10/13** **1/10/13** **1/10/13 and Ongoing** **1/10/13 and Ongoing**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X5) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050115	A. BUILDING _____ B. WING	12/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Continued From page 11 A neurosurgical consultation was obtained on [redacted]11at 9:13a.m. According to the neurosurgeons dictated consultation, a phlebotomist found Patient A at 4:00a.m., unresponsive. The neurosurgeons dictation indicated Patient A remained profoundly thrombocytopenic (low platelet count; platelets assist with blood clotting), with increasing bleeding in the brain and noted, "Any prognosis for any meaningful recovery or survival is virtually nil.." A neurology consultation, obtained on [redacted]11 at 9:38 a.m., concurred with the neurosurgeon. The neurology consultation indicated Patient A had, "Hemorrhage in the pons (brain stem) of a fairly massive scale...deeply comatose prognosis for any meaningful recovery is essentially zero.." Patient A continued to decline and the decision was made to change the level of care to DNR (do not resuscitate) on [redacted]11 at 3:42p.m. Patient A expired on [redacted]11 at 6:47 a.m. The coroner's report, dated [redacted]11, listed the cause of death as, "Complications of blunt force injury of head." The failure of the nursing staff in the IMC to monitor, evaluate and implement nursing care on Patient A resulted in the patient's fall and ultimately death. 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 1280.1(c).		Procedure 18244 "Standards of Patient Care for the Adult Inpatient" outlines the responsibility of the RN for assessment, planning, supervision, implementation and evaluation of care provided. The RN involved in the care of this patient was counseled related to; 1. Failure to follow the CIWA protocol 2. Failure to notify the MD for documented HR over 120 ppm 3. Failure to complete / document complete vital signs and assessment related to the HR 4. Failure to notify the physician of CIWA scores over 15 5. Initiation of O2 for saturations of 96% despite order to maintain oxygen saturations of 92% 6. Failure to call RRT when patient was found unresponsive 7. Importance of accurate documentation of care provided and adherence to physician orders. 8. Notification of the planned audit of 10 medical records for documentation. **Person Responsible:** Rae Anne Watson, RN, Nursing Director **Addendum #2:** Procedure 18244 "Standards of Patient Care for the Adult Inpatient" **Addendum #3**: Staff Counseling Date 11.27.11	**11.27.11**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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