

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>050248</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/26/2007</b>
NAME OF PROVIDER OR SUPPLIER <b>NATIVIDAD MEDICAL CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1441 CONSTITUTION BOULEVARD, SALINAS, CA 93906 MONTEREY COUNTY</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	<p>The following reflects the findings of the California Department of Public Health during a complaint visit.</p> <p>For complaint CA00120039 regarding Quality of Care/Treatment, the Department was unable to substantiate a violation of Federal or State regulations.</p> <p>For entity reported incident CA00126268 regarding Quality of Care/Treatment, a State deficiency was identified (see 70213(a)).</p> <p>Inspection was limited to the specific complaint and entity reported incident investigated and does not represent the findings of a full inspection of the facility.</p> <p>Representing the California Department of Public Health: [REDACTED], Health Facilities Evaluator Nurse.</p> <p>HEALTH AND SAFETY CODE, SECTION 1280.1(a)(c)</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>			

Event ID:NBDP11

3/18/2008

3:23:31PM

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

TITLE

(X6) DATE

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>050248</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/26/2007</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>NATIVIDAD MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1441 CONSTITUTION BOULEVARD, SALINAS, CA 93906 MONTEREY COUNTY</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p><b>Continued From page 1</b></p> <p>The above regulation was not met as evidence by:</p> <p>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.</p> <p>The above regulation was not met as evidence by:</p> <p>DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY.</p> <p>Title 22, Section 70213(a) Nursing Services Policies and Procedures.</p> <p>70213(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.</p> <p>The above regulation was not met as evidence by:</p> <p>Based on interview and documentation in 1 of 1 patient record, nursing staff failed to deliver patient care in a safe manner and in accordance with hospital policy. Findings include:</p> <p>Hospital policy in the mental health unit states, under "Universal Performance Standards", the Staff Nurse II performs job related duties in a safe manner.</p> <p>Patient 1 was brought to the hospital emergency room by the local police on 9/6/07. Documentation</p>			
--	---	--	--	--

Event ID:NBDP11

3/18/2008

3:23:31PM

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

TITLE

(X6) DATE

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>050248</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/26/2007</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>NATIVIDAD MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1441 CONSTITUTION BOULEVARD, SALINAS, CA 93906 MONTEREY COUNTY</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p><b>Continued From page 2</b></p> <p>indicated the patient was placed on a Welfare and Institution Code 5150 (72 hour psychiatric hold for evaluation) as a danger to himself. The patient was assessed by emergency room nursing staff as a possible overdose, depressed, and there was evidence of the patient intentionally cutting himself.</p> <p>Patient 1 was treated and transferred to the hospital's locked Mental Health Unit (MHU) for psychiatric evaluation and care. While on the unit, the patient was checked every 15 minutes. On 9/7/07, at approximately 3:30 p.m. during a 15 minute check, the patient was noted to be missing. A search was conducted and eventually the police were notified the patient had apparently eloped from the unit.</p> <p>On 9/8/07 (next day) the local police found the patient in the community and returned him to the hospital emergency room. He was medically cleared and transferred back to MHU.</p> <p>The hospital investigation of his elopement revealed that Patient 1 followed a Staff Nurse (RN II) out two locked doors by placing his foot between the doors and the doorjambes before the doors closed. The staff member was unaware of the patient behind him.</p> <p>According to the manager of the unit, who was interviewed on 10/19/07, the doors used by the staff member to exit from the unit were not the doors staff normally used. In addition, he stated the staff member should have been aware of his surroundings, noting the patient behind him, in</p>			
--	--	--	--	--

Event ID:NBDP11

3/18/2008

3:23:31PM

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

TITLE

(X6) DATE

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>050248</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/26/2007</b>
NAME OF PROVIDER OR SUPPLIER <b>NATIVIDAD MEDICAL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1441 CONSTITUTION BOULEVARD, SALINAS, CA 93906 MONTEREY COUNTY</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
	<p><b>Continued From page 3</b></p> <p>accordance with policy and acceptable standards of practice for the mental health unit.</p>				

Event ID:NBDP11

3/18/2008

3:23:31PM

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

TITLE

(X6) DATE

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.