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
	050701	A. BUILDING _____ B. WING _____	03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwest Healthcare System	25500 Medical Center Dr, Murrieta, CA 92562-5965 RIVERSIDE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00260367, CA00259865 - Substantiated Representing the Department of Public Health: Surveyor ID # 28294, 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. Abbreviations used in this document: BRP - bath room privileges CNA - Certified Nursing Assistant CT - computerized tomography Dr. - doctor DRM - Director of Risk Management LOC - level of consciousness L-spine - Lumbar spine L > R - left greater than right MD - physician mm - millimeter OOB - out of bed PROM - passive range of motion pt - patient		Initial Comments Southwest Healthcare System received this Statement of Deficiency on May 13, 2014. The hospital reaffirms it commitment to ensuring that the Interdisciplinary Plan of Care is reviewed, updated, and implemented as the patient's clinical condition changes and for nursing to advocate on behalf of the patient should concerns be identified such as confusion following a fall event.	

APOC Implemented 6/2/14

Event ID: BGKC11 5/0/2014 2:14:41PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE CEO (X6) DATE 5/22/2014

By signing this document, I am acknowledging receipt of the notice citation packet. Page(s) 1 thru 12

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.

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	PT - Physical Therapy RN - Registered Nurse RRT - Rapid Response Team S.A.F.E. - Specialty Adult Focused Environment T-spine - Thoracic spine Health and Safety Code Section 1279.1 (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 COPH 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. 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. Title 22 of the California Code of Regulations Section 70215 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. Based on interview and record review, the facility failed:		Continued From page 1 Title 22 of the California Code of Regulations Section 70215 – Planning and Implementing Care Actions Taken: 1. The Nursing Manager met with the nurse involved in the care of Patient 1 to review the patient's clinical status and changes noted surrounding the fall event of [redacted] 2011. This included an educational discussion that included: a. The nurse's responsibility to update the patient's Interdisciplinary Plan of Care (IPOC) with key information when there is a change in the patient's status, such as being found out of bed disoriented and the patient not following instructions to call the nurse for assistance.	2/25/2011

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	(1) To ensure the "Interdisciplinary Plan of Care" was updated, with revised or additional interventions, when the patient (Patient 1) was found standing by the side of the bed on [redacted] 201*, at approximately 7:15 p.m.; (2) To ensure the nurse advocated for the patient (Patient 1) when Patient 1, who had been identified as being at "high risk" for a fall, was found standing by the side of the bed following her return from surgery on [redacted] 2011, and subsequently experienced an unwitnessed fall on [redacted] 2011 at 8:53 p.m., at which time she was confused, disoriented and was unable to answer the question if she had hit her head when she fell. The failures as set forth in (1) and (2) above resulted in Patient 1's fall in the facility, fracture of Patient 1's right femur and Patient 1's subsequent death from a subdural hematoma (collection of blood in the brain). Patient 1's death occurred 126 hours after her initial fall in the facility. Findings On [redacted] 2011, the record for Patient 1 was reviewed. Patient 1 was admitted to the facility on [redacted] 2011 with diagnoses including mechanical fall (fall caused by the environment; a slip, trip or loss of balance) at home which resulted in a left leg tibia/fibula fracture (broken lower leg bones). The "Admission Data Base" dated [redacted] 2011, indicated "Mental/Sensory Status: Alert,		Continued From page 2 b. The option of implementing additional fall prevention interventions (i.e. moving the patient closer to the nursing station or using a bed alarm). c. A review of the Fall Prevention policy and the nurse's responsibilities to perform initial and ongoing patient assessments and to clearly communicate the patient post-fall status (i.e. confusion) to the physician, for appropriate follow-up care. d. Seeking input via the Chain of Command should the nurse have an identified concern and/or recommendation that are not addressed when reporting a patient's condition to the physician, such as a head CT post-fall. 2. The Medical-Surgical Manager supported by the Chief Nursing Officer implemented the SAFE (Safety Adult Focused Environment) Program at Rancho Springs Medical Center on February 22, 2011. The purpose of the program is to provide safe and appropriate patient-centered care for the acutely ill, confused/agitated patient facilitating interacting and engaging patients in their individualized plan of care. Candidates for the SAFE Program include patients at high risk for fall and attempting	2/22/2011

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	Oriented (checked)" and "Mobility: Fall Band Applied (checked)." The "Acute Care Nursing 24 - Hour Flow Sheet" dated [redacted] 2011, at 7 p.m., indicated "High Fall Risk Assessment - Previous Fall; Mobility Problem; Patient less than 4 or older than 65 years old; and Fall Risk Wrist Band in Place" were checked "Yes," and if there were two or more criteria checked the patient was at a high risk for falls. The "Acute Care Nursing 24 - Hour Flow Sheet" dated [redacted] 2011, at 7 p.m., indicated "High Fall Risk Assessment - Previous Fall; Mobility Problem; Receiving Hypnotics, Laxatives or Diuretics; Sedatives; Patient less than 4 or older than 65 years old; and Fall Risk Wrist Band in Place" were checked "Yes," and if there were two or more criteria checked the patient was at a high risk for falls. The "Acute Care Nursing 24 - Hour Flow Sheet" dated [redacted] and [redacted] 2011, indicated Patient 1 was "Instructed to Call for Assistance" and was on "Bedrest." The "Interdisciplinary Plan of Care" dated [redacted] 2011, indicated: a. "Nursing Diagnosis/Problems Identified - Impaired Physical Mobility/Activity Intolerance Related to: Unsteady gait/poor balance (marked with a check) and Surgery (marked with a check);" b. "Goals - Prevent Falls (marked with a check);" c. "Interventions - Institute fall protocol, Assess fall		Continued From page 3 to get out of bed regularly, propensity for pulling out tubes and lines, require frequent safety checks who are at the medical-surgical or progressive care unit level of care. Program development began in December 2010 and the implementation plan included the development and approval of the policy and SAFE orders. Education was provided to those who would be assigned to SAFE Program patients regarding expectations and the aspects of providing care to confused and/or agitated patients. SAFE Program resource information was provided and is maintained on the nursing unit. Program components include rehabilitation services, social service/care coordination and pharmacy evaluation, patient/family education, diversional activities, fall precautions, and a toileting schedule. The SAFE Program was initiated on [redacted] 2011 and the physician provided SAFE orders for Patient 1 on this date. 3. The Medical Surgical Manager provided education for all of the Rancho Springs medical-surgical-telemetry nursing staff regarding interventions for high	3/31/2011

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	risk per policy; Check patient frequently; Ensure call cell in reach; Advise patient not to get OOB (out of bed) by themselves; Clear pathway to BRP (bathroom privileges) with adequate lighting; Recheck patient soon after narcotics, sedatives; Turn and reposition every _____; Assess weight bearing status and document patient ability; Involve PT (physical therapy) as appropriate for adequate follow-up to mobility issues; and Ensure activity level is carried out as ordered unless patient not tolerating, then discuss with MD (physician) PROM (passive range of motion)" were all marked with a check. There was no indication the "Interdisciplinary Plan of Care" had been updated with revised or additional interventions when Patient 1 was found standing by the side of her bed on [redacted] 2011, at approximately 7:15 p.m. On April 8, 2011, at 8:04 a.m., an interview was conducted with RN 2. She stated Patient 1 returned from surgery at approximately 6 p.m., on [redacted] 2011, with a cast on her left leg. RN 2 stated Patient 1's level of consciousness was a "1" (arousable, partial reflexes) and Patient 1 was "not totally alert and not really sleepy." RN 2 stated Patient 1's husband was in the room with her until 7:15 p.m., when he stated he was going home. On [redacted] 2011, at 9 a.m., an interview was conducted with CNA 1. She stated Patient 1 was standing by the side of the bed as she was passing the room at approximately 7:15 p.m. CNA 1 stated		Continued From page 4 fall risk patients who are confused or not following directions. These interventions include room assignment closer to nursing station, sitter, SAFE Program, fall mats, bed alarm, low beds, family involvement and diversion activities. As a part of this education, updating and individualizing the patient's IPOC to include patient information and interventions was reinforced to the nursing staff. 4. The Chair of the Fall Prevention Team revised the Fall Prevention policy to clarify wording associated assessments and reassessments including the requirement for an assessment/reassessment every shift and as needed and elements of a post fall assessment including a physical assessment and vital signs and the communicate pertinent information in the nurse's shift report in order to assess for any delayed reaction to the fall such as a change in level of consciousness or increased pain. The policy was approved by the Board of Governors. 5. Fall Prevention was included in the annual competency event and was attended by the nursing staff as part of each nurses' evaluation process. Information included assessment	4/28/2011 6/30/2011

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	she called for assistance by pushing the call light and RN 1, the night nurse, came into Patient 1's room. CNA 1 stated Patient 1 just wanted to go the bathroom even though she was not supposed to get out of bed, and needed to use the bed pan. CNA 1 stated she and RN 1 assisted Patient 1 back into bed and she then left the room. On April 8, 2011, at 7:20 a.m., an interview was conducted with RN 1. The following facts were relayed by RN1 during the interview: a. CNA 1 came to RN 1 on [redacted] 2011, while she was receiving report from the off going shift nurse. CNA 1 stated Patient 1 was trying to get out of bed. RN 1 stated when she went to the room, at approximately 7:23 p.m., Patient 1 was sitting on the side of the bed with her back to the door. RN 1 stated the top side rails were up and there was no other person in the room except CNA 1 and the patient. RN 1 stated she asked Patient 1 what she was doing and Patient 1 stated she needed to go to the bathroom. RN 1 stated she and CNA 1 assisted Patient 1 back to bed, and RN 1 stayed with the patient until she was finished using the bed pan. RN 1 stated the cast on Patient 1's left leg did not inhibit her movement, she told the patient to press the call button if she needed help, and Patient 1 said she knew which button to push if she needed a nurse. b. RN 1 stated she went back to Patient 1's room between 7:50 p.m. and 8 p.m., to complete her shift assessment. RN 1 stated the patient was sleeping when she entered the room, she woke the		Continued From page 5 reassessment, care plan problem identification, and post fall actions. 6. Nursing leadership reviewed the Care Planning and Assessment/Reassessment of Patient policy with discusses the process for patient reassessment and reassessments of the patient's care and treatment. Nursing leadership also reviewed the IPOC form. No revisions were necessary. 7. Nursing leadership inserviced all clinical nurses on their responsibilities associated with the Care Planning, Fall Prevention Program and Assessment/Reassessment policies. Special emphasis was given to: a) The importance of the IPOC as a tool to effectively communicate the patient's plan of care among all disciplines involved in the patient's care. b) The importance of revising/updating the IPOC to reflect any changes in the patient's status based on evaluations by nursing (i.e. patient's unwilling/unable to corporate with safety instructions such as calling for assistance to get out of bed, or a post-fall assessment)	7/27/2011 9/6/2011

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	patient, asked the patient if she had any pain, and Patient 1 denied any pain or having any needs. RN 1 stated Patient 1 appeared alert and oriented, but was very quiet c. RN 1 stated she went back into Patient 1's room between 8:30 p.m. and 8:45 p.m., to give Patient 1 her medication. RN 1 stated the patient was resting with her eyes closed at that time. d. RN 1 stated she was walking by Patient 1's room at approximately 8:53 p.m., and went into the room to give the patient her antibiotic. RN 1 stated the patient was not in her bed and she could not see the patient. RN 1 stated she found Patient 1 on the floor lying on her left side, her head was up and Patient 1's hand was on her right thigh "not saying anything just lying on the ground." RN 1 stated Patient 1 did not say much, and when asked "Where are you hurt?" and "Did you hit your head?" Patient 1 responded "My thigh, my thigh, my thigh." RN 1 stated Patient 1 would not answer her when she asked Patient 1 if she hit her head. RN 1 stated she asked the patient what she was doing, and Patient 1 responded "I am looking for my husband." RN 1 stated Patient 1 was confused and disoriented. e. RN 1 further stated, she called the physician and told him Patient 1 had experienced an unwitnessed fall, how the patient was lying on the floor, and Patient 1 was complaining about her right thigh. RN 1 stated she asked the physician if he wanted a "CT (examines the various structures of brain to look for a mass, stroke, area of bleeding, or blood		Continued From page 6 c) The need for a patient reassessment at regularly specified times related to the patient's course of treatment, at least every shift and more often as indicated by department standards, as well as based upon individual patient needs such as a fall, or change in their clinical status. d) Documenting patient assessment/reassessment on applicable forms and to revise the patient's IPOC to promote the safe and effective care of the patient throughout the hospital stay, such as completing a patient comprehensive assessment after a fall. e) Ensuring that the post-fall assessment and vital signs including neurological status are clearly communicated to the physician regarding the patient's status/change in condition. f) Implementing the chain of command if assistance is needed in evaluating a situation or if there is a concern regarding patient care needs. Education was also provided on the actual drafting of plans of care to ensure that nursing staff understand how to document applicable interventions to problems identified.	

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	vessel abnormality) of the head because of the unwitnessed fall." RN 1 stated the physician ordered an x-ray of the right thigh. f. RN 1 stated Patient 1's only complaint was her right thigh but she was confused. RN 1 stated when someone falls in the facility, a constant observer/sitter was assigned to the patient, and a constant observer/sitter was assigned to Patient 1 after she fell. g. RN 1 stated she did one neurological check right after Patient 1 fell but no additional neurological checks were done for the remainder of her shift which ended at 7:30 a.m., on [redacted] 2011. RN 1 stated Patient 1 "remained disoriented throughout the evening" and was better once her husband arrived. On March 29, 2011, at 4 p.m., an interview was conducted with the Director Risk Management (DRM). She stated the facility did not have a post fall procedure in regards to assessments, neurological checks, and vital signs. The "Diagnostic Imaging Report" dated [redacted] 2011, indicated " There is an angulated foreshortened fracture of the proximal femur on the right." On August 16, 2011, at 8:35 a.m., an interview was conducted with Manager 1. She stated if the patient was identified as being at risk for a fall and the patient was found standing at the bedside the nurse should put the patient back in bed; assess		Continued From page 7 8. The Director of Nurses developed and implemented a post-fall tool for the managers to use when reviewing a fall incident. The tool included the parameters of a complete post-fall assessment including causative factors and action taken to implement preventative measures, vital signs, physical assessment including skin, pain and neurological assessment. The tool prompts the nurse to contact the physician regarding the fall and patient assessment, thus advocating for the patient's well being. Post-fall imaging studies are ordered on a STAT basis. 9. The Medical-Surgical Manager ensures that nurse staff assigned to the Rancho Springs Medical Surgical and Progressive Care are educated to the SAFE Program and receive periodic updates regarding the care of confused and/or agitated patients 10. All registered nurses are educated to the Care Planning, Assessment/Reassessment, Fall Prevention, Hand-off Communication, and Chain of Command policies and procedures. Information is also incorporated in unit-based shift huddles and during annual orientation.	12/1/2011 Upon Hire and periodically Upon Hire and Annually

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	why the patient was standing at the bedside; maybe move the patient closer to the nurses' station for closer observation. If the patient was confused, possibly place a sitter with the patient; and institute/review the care plan for safety, fall risk, and fall precautions. The "Perioperative Record" dated [redacted] 2011, indicated Patient 1 went to surgery at 8:50 a.m. for the surgical procedure of repairing Patient 1's right femur by inserting a rod, and Patient 1 was returned to her room at 12:05 p.m. The "Acute Care Nursing 24-Hour Flow Sheet" dated [redacted] 2011 indicated on February 21, 2011, at 6:50 a.m., "Pt's (Patient's) spouse expressed concerns re: pt experiencing pain to back." The "Physicians Order Sheet" dated [redacted] 2011, at 7 a.m., indicated "x-ray T-spine (thoracic spine) and L-spine (lumbar spine)." The "Diagnostic Imaging Reports" dated [redacted] 2011, indicated "... Chronic-appearing T12 compression fracture." and, "There are central compression fractures of the L3 and L4 vertebral bodies, age indeterminate." The "Physician's Order Sheet" dated [redacted] 2011, at 8:15 a.m. indicated a chest x-ray was ordered. The "Diagnostic Imaging Report" dated [redacted] 2011 indicated "old and new left rib fractures,		Continued From page 8 Nurses complete a computer-based learning module annually on the topic of implementing the chain of command. Monitoring. 1. The Fall Prevention Committee provides a quarterly report regarding fall events. The Medical-Surgical Manager evaluated the impact of the SAFE Program including the incidence of patient falls in this patient population. The Manager provided an update to the Chief Nursing Officer and reported this to the Fall Prevention Committee at the October meeting. Information forwards through the quality oversight structure to the Board of Governors. 2. The Director of PI (or qualified designee) performs a concurrent record review for the following: a. A minimum of 30 patient fall records per month or 100% of patient falls if less than 30 events with the goal of achieving 100% compliance with the Fall Prevention policy. b. A minimum of 50 records monthly with the goal of achieving 100% compliance with developing sufficient nursing care plans.	7/1/2011 10/1/2011

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	the acute fractures appearing to involve the left 5th through 7th ribs." " The "Acute Care Nursing 24-Hour Flow Sheet" dated [redacted] 2011, indicated: a. At 6:50 p.m., Patient 1 received Dilaudid (an intravenous medication used to relieve moderate to severe pain). b. At 7:35 p.m., " patient very lethargic, respond only to painful stimuli . (Name of day shift RN) stated she (Patient 1) gets drowsy after the Dilaudid." c. At 7:45 p.m., the assessment indicated "LOC (level of consciousness) very lethargic, respond to pain. Verbal response: None. Behavior: Sedated." d. At 8:15 p.m., "patient still with difficulty responding . called (name of nurse) RRT (Rapid Response Team) to assess the patient;" e. At 8:25 p.m., "called Dr. (name);" f. At 8:40 p.m. "patient pupil dilated to 4 mm L > R (left greater than right) and unreactive light, patient still unresponsive;" g. At 8:45 p.m., "Dr. (name) responded orders given and carried out." h. At 9:15 p.m., "patient went to CT of brain." A CT of Patient 1's brain was not ordered until [redacted] 2011, at 9:15 p.m., 96 hours after Patient 1 fell in the facility. The "Diagnostic Imaging Report" dated [redacted] 2011, indicated "Large left frontoparietal subdural hematoma . The ward nurse was notified by critical call at 9:30 p.m."		Continued From page 9 Data is presented at the hospital's performance improvement committee for analysis and action planning as warranted. The report forwards through the quality oversight structure to the Board of Governors. Person Responsible: Chief Nursing Officer	

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	The "Death Report Form" dated [redacted] 2011, indicated Patient 1 was pronounced dead on [redacted] 2011, at 2:50 a.m. The State of California, Certification of Vital Record, County of Riverside, Certificate of Death for Patient 1, dated [redacted] 2011, indicated the "Immediate Cause (Final disease or condition resulting in death) (A) Subdural Hematoma (collection of blood in the brain)" and "Underlying Cause (disease or injury that initiated the events resulting in death) (B) Blunt Force Craniocerebral (head) Trauma." The facility Policy and Procedure entitled, "Care Planning: Patient," dated January 2011, sets forth under section (H) of the heading entitled "Policy" the following: "The patient's care plan shall be revised/updated to reflect changes in the patient status, as evaluated and assessed by the Registered Nurse and other members of the healthcare team. However, there were no revisions or updates to Patient 1's care plan after Patient 1 was found standing at her bedside without assistance. The facility's failure to revise Patient 1's care plan to include new interventions for Patient 1 when Patient 1 was at high risk for falls and after Patient 1 demonstrated inability to follow instructions to not get out of bed and to use the call light for assistance, is a deficiency 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		Continued From page 10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050701	A. BUILDING _____ B. WING _____	03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwest Healthcare System	25500 Medical Center Dr, Murrieta, CA 92562-5965 RIVERSIDE COUNTY

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	1280.1 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)		Continued From page 11	