The following reflects the findings of the Department of Public Health during the investigation of Complaint # CA 00139414.

Representing the Department: HFEN #1700

The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.

T22 DIV5 CH1 ART3-70213 - Nursing Service Policies and Procedures.
(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.

This RULE: is not met as evidenced by:
Based on staff interview and clinical record review the facility failed to ensure policies and procedures (P&P) were implemented for patient care related to fall prevention and restraints. The P&P Fall Prevention (11/10/03) and the Use of Physical Restraints P&P (4/16/07) were not followed for Patient 1 who was assessed at high risk for falls on admission. The Patient Care Plan did not indicate interventions such as monitoring the patient closely, or placing bed in low position as per P&P. Staff used restraints without clinical justification for use and without appropriate assessments. On 1/20/08 at 12:15 p.m. Patient 1 fell out of bed and sustained displaced left femur fracture. Patient 1 expired on 1/23/08.

The facility's failures resulted in harm to Patient 1, constituting an Immediate Jeopardy (IJ). The IJ was

We have undertaken the following corrective actions for the patients identified to have been affected by this issue:

- A review and revision of the hospital's Fall Prevention and Management Policy was initially completed in October, 2008 to identify additional methods of identification of Fall Risk patients. We further completed a revision of this policy on 6/22/09 to include the use of Morse Fall Risk Assessment Scale. Staff was educated on the revised methods of identification of Fall Risk patients, including the implementation of the use of a yellow arm band, yellow blanket, yellow non-skid slippers and a large 8 ½” by 11” sign at the head of the bed to indicate that a patient is a fall risk. In-service of staff was undertaken in several stages and completed for all patient care staff via competency by 7/29/09.

- A review and revision of the hospital's Fall Prevention and Management Policy was done to ensure that the "bed alarms" are listed as one of...
CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:
059366

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
06/12/2009

NAME OF PROVIDER OR SUPPLIER
MARK TWAIN ST. JOSEPH'S HOSPITAL (4RH)

STREET ADDRESS, CITY, STATE, ZIP CODE
768 MOUNTAIN RANCH ROAD, SAN ANDREAS, CA 95249 CALAVERAS COUNTY

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LIC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Each corrective action should be cross-</td>
</tr>
<tr>
<td></td>
<td>refereed to the appropriate deficiency)</td>
</tr>
<tr>
<td></td>
<td>(X5) COMPLETE DATE</td>
</tr>
</tbody>
</table>

Continued From page 1
called on 6/12/09 at 2:15 p.m. with the hospital's administrative and risk management staff.

On 6/15/09 the facility presented written acceptable plan of correction that included revisions to P&P and staff training. The PJ was lifted on 6/24/09 at 3:55 p.m. with the administrative and risk management staff present after the facility presented and implemented the plan of correction, confirmed during an on-site visit.

Findings:

Review of the P&P for Fall Prevention (11/10/03) indicated patients' fall risk potential will be assessed on admission and every shift. Fall Prevention Protocol will be initiated at any time indicated by the Admission Assessment or by the 24 Hour Flow Sheet guidelines. The procedure section directed to refer to Fall Prevention Patient Care Plan. The nurses' notes should include documentation that Fall Prevention protocol was in effect and of "patient's mental, physical condition, behavior and any changes of the same." The Patient Care Plan for Patients With Fall Prevention indicated interventions should include monitoring patients closely, place bed in low position, side rails must be up at all times, use restraint devices only if absolutely necessary (obtain order from physician) and utilize other measures to monitor patient such as bed check device, family member at bedside, bed rail alarm.

The P&P Use of Physical Restraints (4/16/07) indicated (section 2.1) the use of restraints will be continued from Page 1

the methods of fall risk precautions. In-service of staff on the use of the bed alarms was undertaken in several stages and completed for all patient care staff via competency by 7/29/09.

- A review and revision of the hospital's Fall Prevention and Management policy on re-assessment expectations and hospital's patient fall notification process was completed by February 2008. In-service of staff was undertaken in several stages and completed for all patient care staff via competency was by 7/29/09.

- A review and revision of the hospital's Fall Prevention and Management Policy on the activities to be undertaken by the supervisory staff in the event of a patient fall was completed by February 2008. A Supervisor/Management Fall Assessment worksheet was devised to be used by the House Supervisor, Charge Nurse or Department Manager in the event of a...
## Statement of Deficiencies

### Provider/Supplier ID: 059366

**Mark Twain St. Joseph's Hospital (4RH)**

**Street Address, City, State, Zip Code:** 768 Mountain Ranch Road, San Andreas, CA 95249, Calaveras County

### Provider ID: 059366

**Summary Statement of Deficiencies**

Continued from page 2

- done in a manner that protects the patient's health and safety and preserves his/her dignity, rights and well-being. Restraint use will be limited to actual actions (Acute Medical/Surgical Restrains) or behaviors (Behavioral Restrains) that could cause harm to self or others (section 2.3). Acute Medical Restrains will be only used if needed in attaining or maintaining patients' practicable level of well being if less restrictive interventions have been ineffective and if the patient is at risk for interruption of medical therapeutic interventions. Physician will see and evaluate the patient within 24 hours of initiation of restraints (section 2.4). The patient will be observed every 15 minutes with restraint release every 2 hours. Physical restraints included vest and bottom side rails (section 4.2).

- Section 6.1 indicated that the use of restraint is limited to those situations for which there is adequate and appropriate clinical justification as well as proof that the use of alternatives poses more risk than restraint and all alternatives have been considered and attempted as appropriate.

- Section 7.1.2 indicated that the use of restraint occur only after all non-physical restraint alternatives to such use have been considered and attempted as appropriate. Such alternatives include, but are not limited to, increased observations and monitoring and use of a sitter.

- Sections 13.0-13.1.3 for assessments indicated each patient will receive a comprehensive assessment prior to the use of any restraint device. All appropriate restraint alternatives will be

### Providers Plan of Correction

Continued from Page 2

- patient fall. In-service of the appropriate staff was completed via acknowledgement by 03/26/09.

- As part of the review and revision of the hospital's Fall Prevention and Management Policy, a Sitter Algorithm was devised to aid the staff in determining the need for sitter for appropriate fall risk patients. In-service of staff was undertaken in several stages and completed for all patient care staff via competency by 7/29/09.

- Concurrent monitoring of all medium or high fall risk patients is being conducted using the following criteria: completion of Fall Risk Assessment on every shift; Implementation of fall identification strategies for every appropriate patient; use of the bed alarms for all high fall risk patients. Concurrent monitoring will be conducted for the next three months from 7/22/09, or until

---

**Event ID:** 1HE211

**7/15/2009 8:05:11 AM**

**Laboratory Director's or Provider/Supplier Representative's Signature**

**Title**

**[X8] Date**

---

*Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be exempted from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are discoverable 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 discoverable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.*
california health and human services agency
department of public health

statement of deficiencies and plan of correction

(name of provider or supplier)
mark twain st. joseph's hospital (4rh)

405360

08/12/2009

(street address, city, state, zip code)
788 mountain ranch road, san andreas, ca 95249 calaveras county

summary statement of deficiencies
(each deficiency must be preceded by full regulatory or lsc identifying information)

ID prefix tag
(x4) ID prefix tag

providers plan of correction
(each corrective action should be cross-referenced to the appropriate deficiency)

ID prefix tag

(continued from page 3)
evaluated for use and all appropriate alternatives will be attempted and documented. The comprehensive assessment of the patient must determine that the risks associated with the use of the restraint are outweighed by the risk of not using it.

section 14 orders for restraints showed only a physician or a licensed practitioner may order restraint and standing orders are not acceptable. The order will include type of restraint, specific reason and circumstances for its use, duration of application and plan for progressive removal. An order is needed if restraints are removed and then replaced due to a change in the patient's condition. Continued use of restraint beyond the first 24 hours will be authorized by face to face assessment and written order clinically justifying the continued use of restraint.

section 15 indicated that after restraints are applied an immediate assessment will be completed to ensure that restraints were properly and safely applied. The assessment will be documented and include proper application of restraints, the patient's response, and if negative, the changes that were made.

section 19 for documentation indicated patient medical record for each episode of restraint will include the reevaluations of the patient by the rn and/or physician. plan of care documentation should reflect outcome oriented goal related to restraint use, description of interventions, discontinuance of the restraints and care plan update after restraint intervention is discontinued.

(continued from page 3)
compliance goal of 100% for the listed criteria is achieved.

- a review of the hospital's use of physical restraints policy was completed on 6/15/09. all patient care staff was re-educated via competency on treating "4-side rails up" as restraints, the use of sitter algorithm, and the use of and documentation of implementation of alternatives to restraints by 6/24/09.

- we revised the physician order for acute medical/surgical restraints from to include "4 side rails" in the restraint type category. we have informed our physicians via memo distribution on 6/22/09.

- we revised and updated the following hospital-use forms to include all appropriate information for fall prevention and restraint management:
  o interdisciplinary plan of care by removing the "rails up x4" as a fall

event id: 1he211
7/15/2009 8:05:11am

laboratory director's or provider/supplier representatives signature

(title)

(date)
The medical record review on 5/21/08 with the facility management staff showed the following:

The 1/16/08 History and Physical Indicated Patient 1 was 81 year old admitted to the hospital from board and care facility with diagnoses of altered level of consciousness secondary to psychotropic medication (Risperdal), right humeral (arm) fracture resulted from a fall, agitation, dementia, anemia and congestive heart failure. The admission orders showed admission to medical/surgical floor on bed rest. On 1/18/08 the physician progress note indicated the plan for Patient 1 was pain control, orthopedic consult and discharge to SNF (Skilled Nursing Facility) in AM. A progress note on 1/19/08 at 11:10 a.m. showed that the SNF was refusing to take the patient today (Saturday) and will accept the patient on Monday (1/21/08). The physician progress note documented on 1/20/08 (no time) that arrangements were made for Patient 1 to discharge on 1/21/08.

Review of physician orders showed an order on 1/17/08 at 4:00 a.m. for Haldol (antipsychotic) 0.5 mg intravenously to be given “now” and to repeat in one hour if needed for agitation. On 1/17/08 at 6:30 a.m. an order was written for Haldol 1 mg intramuscular or oral dose every six hours as needed for agitation and “restraints pm (as needed).” The order contained no type of restraints, specific reason and circumstances for its use. There was no plan for progressive removal of the restraints as per P&P for physical restraints (section 14).

Continued from Page 4

- Concurrent monitoring of all patients in restraints is being conducted using the following criteria: presence of appropriate restraint order and documentation; presence of documentation of use of alternative and less restrictive methods of restraints were attempted prior to restraint application; completion and documentation of patient assessment every two hours for patients in non-behavioral prevention intervention;
- Interdisciplinary Plan of Care to ensure that a “Yellow Fall Risk armband” selection is available to identify patients at medium and high risk for falls;
- Patient Care and Acuity Record to specify the number of side rails up to include a choice of x2, x3 or x4.

All patient care staff was informed on the form changes via acknowledgement by 6/22/09.

6/22/09
Continued from page 5

The medical record contained Physician Order for Acute Medical/Surgical Restraint form with preprinted reason for restraint. This intervention is required because alternative interventions attempted were found ineffective. The form showed initial order on 1/2/08 for wrist restraints for "disconnecting/removing medical/therapeutic devices." The length of time for the use was 24 hours. The order was renewed on 1/16/08 at 10:00 a.m. with indication added "attempting to get out of bed," also for 24 hours duration. The order was not renewed on 1/18/08. The record contained no evidence of clinical justification and proof that the use of alternatives posed more risk than restraints and what alternatives have been considered and attempted, as per restraint P&P (sections 6.1 and 7.1.2).

Patient 1's medical record showed care plan for fall prevention was initiated on 1/16/08 as Patient 1 was identified at high risk for falls. The Interventions were: fall risk management such as rails x 4 and fall risk sign. The section "restraint protocol" was not check-marked. There were no updates to the fall care plan. The nurses' notes contained no documentation that Fall Prevention protocol was in effect as per Fall Prevention P&P. The Patient Care Plan did not indicate interventions such as monitoring the patient closely, or placing bed in low position as per P&P. There was no plan of care or any documentation that reflected outcome oriented goals related to the use of restraints ordered on 1/17/08 and 1/18/08. There was no description of interventions and no care plan updates after

Continued from Page 5

restraints and every 15 minutes for patients in behavioral restraints; presence of a valid physician restraint order for each restraint episode; and presence of documentation of all required criteria on the physician restraint orders. The concurrent monitoring will be conducted for the next three months from 6/2/08, or until compliance goal of 100% for the listed criteria is achieved.
Continued from page 6

restraint intervention was discontinued on 1/19/06, as per P&P for use of restraints (section 19).

Review of progress notes for the night shift on 1/19/06 to 1/20/06 showed at 8:00 p.m. Patient 1 removed her identification band, hospital gown, refused blanket, and was uncooperative. At 9:00 p.m. the nurse noted bed alarm was set. There was no documentation showing if bed rails were up or down. The notes indicated the patient was calm most of the remaining night shift and that at 7:00 a.m. report was given to the AM shift. The AM shift nurse documented at 8:00 a.m. the patient was incontinent of stool, hands soiled difficult to clean, right arm edema and purple discoloration from mid-arm to chest area. At 10:30 a.m. the nurse documented that the patient was incontinent and changed. The patient continued to be disoriented, moving in bed, was repositioned and was given Haldol for agitation, pulling off brief pants and gown.

The next nursing note on 1/20/06 at 12:15 p.m. documented that Patient 1 was found on the floor lying on her left side in fetal position, calling out to get her off the floor. The patient was noted complaining of pain in legs and right arm. The patient was placed back to bed then to Gen chair and the physician was notified at 12:25 p.m. Orders were received for bilateral hip x-rays. At 3:30 p.m. the nurse documented x-rays showed displaced left femur fracture. The record showed radiology report for date of exam on 1/20/06 that indicated clinical impression-ground level fall, with impression documented: displaced left femur fracture.
continued from page 2

The medical record showed the patient had a history of falls and was considered a high-risk fall patient.

The physical examination revealed the patient was alert and oriented x4. She was able to ambulate with the assistance of a walker. However, she appeared to be in pain and was having difficulty breathing. The patient was noted to be diaphoretic and cyanotic.

The respiratory rate was 24 breaths per minute, and the heart rate was 120 beats per minute. The blood pressure was 100/60 mm Hg. The patient was noted to have a Glasgow Coma Scale score of 15.

The patient was given oxygen via nasal cannula at 2 L/min. The patient was given pain medication according to the pain management protocol.

The patient was observed closely for signs of respiratory distress. A chest X-ray was ordered to determine the cause of the patient's breathing difficulties. The patient was transferred to the ICU for further monitoring and management.

On further questioning, the patient reported a history of chronic obstructive pulmonary disease. The patient was also found to have a history of congestive heart failure and diabetes mellitus.

The patient's family was notified of the patient's condition and was asked to arrive at the hospital as soon as possible. The patient was also placed on a do-not-resuscitate order.

The patient's condition was monitored closely by the medical staff. The patient was administered oxygen therapy, pain medication, and diuretics as needed.

The patient's symptoms improved gradually, and the patient was transferred back to the floor after 48 hours. The patient was discharged home on the seventh hospital day.

The patient's family was given follow-up instructions for the patient's care. The patient was instructed to follow up with her primary care physician and to take her medications as prescribed.

The patient's discharge medications included atenolol, metformin, and aspirin.

The patient was instructed to continue to take the medications as prescribed by her primary care physician.

The patient was also advised to call her primary care physician if she had any questions or concerns regarding her medications.

The patient was discharged home in good condition.

The patient's symptoms improved gradually, and the patient was transferred back to the floor after 48 hours. The patient was discharged home on the seventh hospital day.

The patient's family was given follow-up instructions for the patient's care. The patient was instructed to follow up with her primary care physician and to take her medications as prescribed.

The patient's discharge medications included atenolol, metformin, and aspirin.

The patient was instructed to continue to take the medications as prescribed by her primary care physician.

The patient was also advised to call her primary care physician if she had any questions or concerns regarding her medications.

The patient was discharged home in good condition.
Continued From page 8

thought side rails were up when she found the
patient. She was not sure if bed alarm was set or
not.

On 1/21/08 (no time) the physician documented in
the progress notes that Patient 1 fell out of bed
yesterday and was found to have femur fracture.
The patient was noted lethargic, unable to answer
questions. The progress notes and anesthesia
notes on 1/21/08 indicated the patient was
considered for a surgery but surgery was
postponed due to the patient's current condition
(dehydration and hypokalemia). Progress notes on
1/23/08 indicated that family was advised against
surgery and the patient was placed on comfort
care. The progress notes indicated Patient 1
expired on 1/23/08.