The following reflects the findings of the Department of Health Services during an investigation of COMPLAINT NO. CA00136330.

Inspection was limited to the specific complaint (s) investigated and does not reflect the findings of a full inspection of the facility.

Representing the Department of Public Health:

[Redacted], RN, Health Facilities Evaluator
[Redacted], MD, Medical Consultant
[Redacted], Health Facilities Evaluator Nurse
[Redacted], Health Facilities Evaluator Nurse

HSC 1280.1 (a)(c)

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.

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.
Continued From page 1

Health and Safety Code Section 1317(a) Emergency services and care shall be provided to any person requesting the services or care, or for whom services or care is requested, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility licensed under this chapter that maintains and operates an emergency department to provide emergency services to the public when the health facility has appropriate facilities and qualified personnel available to provide the services or care.

Health and Safety Code Section 1317.1. Unless the context otherwise requires, the following definitions shall control the construction of this article:
(a) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.
(b) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
(1) Placing the patient's health in serious jeopardy.
(2) Serious impairment to bodily functions.
Continued From page 2

(3) Serious dysfunction of any bodily organ or part.

The above Statutes were NOT MET as evidenced by:

Based on observation, interviews and a review of policies and procedures and medical records, the hospital failed to provide a medical screening examination and further stabilizing treatment for two patients presenting to the emergency department for the evaluation of an emergency medical condition (Patients #33 and #46). The failure to provide a medical screening examination for these two patients presenting with chest pain, resulted in the potential failure to recognize and treat a heart attack, and the identification and declaration of an Immediate Jeopardy (IJ) situation. The hospital administrator was informed of the IJ finding at 1450 hours on 2/1/08.

Findings:

1. The medical record for Patient #46 was reviewed on 2/1/08. Patient #46 came to the emergency department of the hospital on 1/3/08 at approximately 0022 hours. Patient #46 was seen in triage at 0030 hours on 1/3/08. The triage assessment revealed a chief complaint of left chest pain radiating to the left arm of two days duration. Patient #46 stated that she took "Nitro/ASA" (Nitroglycerin is utilized for patients with the chest pain of Angina Pectoris, as a rapid coronary artery dilator, to improve the chest pain. Aspirin (ASA), is used as a platelet and clotting inhibitor for these patients), and stated that the pain "eased up" but had not gone away. The patient rated the remaining pain as a 7 on a 1-10 scale (10 being the...
Continued From page 3

worst pain). The triage nurse documented a blood pressure of 161/99 and a blood sugar of 247. Both of these values would be considered elevated.

Current medications listed for Patient #46 included Lisinopril (a medication used to treat hypertension), Atenolol (a medication used to treat hypertension and Angina Pectoris), Vitorin (a medication used to treat elevated cholesterol), Glyburide, Metformin and Actos (Oral anti-diabetic medications). Patient #46 also had Nitroglycerin and Aspirin prescribed as current medications.

An electrocardiogram (EKG) was obtained at 0100 on 1/3/08. The computer print out read the study as “abnormal” with an ST-T wave abnormality. There was a signature indicating that this EKG had been reviewed by MD H, a member of the resident physician staff in the ED. Patient #46 was assigned a triage category of "urgent" and an acuity of 2. On 2/1/08 the hospital Policy and Procedure for "Triage and Medical Screening Examination," identified this triage category was "Emergent-Rush." Patient #46 was not taken back to the treatment area and no further medical screening examination by a physician was conducted.

On 2/1/08 the Policy and Procedure for "Daily Patient Care Guidelines" stated that in the triage area, routine vital signs and pain assessments were to be done every four hours. There was no documented evidence that attempts were made to obtain Patient #46's vital signs and pain assessment again at 0430 hours on 1/3/08. Patient #46 was called at 0605, 0800 and 0900.
Continued From page 4

hours, but there was no response. There was no documentation that Patient #46 received a medical examination by a member of the physician staff, despite complaints of active chest pain partially relieved by Nitroglycerin. There was no documentation that Patient #46 received stabilizing treatment for her chest pain, abnormal EKG, elevated blood sugar and/or the elevated blood pressure despite complaints of active chest pain partially relieved by Nitroglycerin. It was documented that the patient left without being seen.

2. The medical record for Patient #33 was reviewed on 1/31/08. Patient #33 came to the emergency department via ambulance at approximately 0135 hours on 8/24/07. Patient #33 was assessed in the ED while still on the paramedic gurney and assessed as "OK to send to triage" by MD L. Patient #33 was assessed by the triage nurse at 0140 hours. Patient #33 complained of "chest pain that had been relieved by three nitroglycerin sprays and administration of aspirin while still en route to the hospital." Patient #33 stated that the pain was in the left chest radiating to the left arm and initially was 7/10 but had improved to 2/10. Patient #33 stated that the pain had lasted for approximately 3 hours. An EKG obtained was normal.

At 0330 hours, Patient #33 was re-assessed in triage. Patient #33 had vital signs obtained that were in the normal range, but continued to complain of increasing chest pain of 9/10, with intensification of pain since the initial triage evaluation of 0140 hours. There was no
Continued From page 5
documentation that the triage nurse notified a physician of the patient's increased chest pain. Patient #33 was summoned at 0830 hours and again at 1343 and 1630 hours, but there was no response. There was no documented evidence of a medical screening examination or stabilizing treatment for Patient #33.

At 1340 hours on 1/31/08 the lobby of the main ED was observed. There were approximately 10 patients waiting in the line to be called to the window for screening and/or triage. There were approximately 30 other people sitting in the lobby chairs. One triage nurse was observed to be directing the registration clerks to register some patients. The nurse told the clerk that there were three chest pain patients that had been there since 1000 hours that had not been registered and/or seen for evaluation and treatment. The triage nurse was in the area by herself and stated that the ED had been really busy. During confidential interviews, two of five nursing staff stated that the triage area was short staffed. The Associate Director of Nursing stated that at times there could be up to 95 patients in the ED lobby at one time. Typical staffing for the triage area was two to three nurses.

MD X stated that a trainee physician was provided at the ambulance entrance of the ED, to cope with a stream of patients, constantly arriving to the hospital. These physicians, experienced in emergency care, were to immediately assess the arriving patient to determine the status and acuity of the emergency medical condition and to assign those patients to wait in the waiting room, for triage...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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**SUMMARY STATEMENT OF DEFICIENCIES**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

Continued From page 6

by the registered nurses assigned to that area. Waiting in triage frequently required many hours owing to the large patient load. MD X stated that approximately 10% of the emergency department patients leave the ED without being seen, owing to the large number of adult patients being screened to determine the presence of an emergency medical condition. MD X stated that this short staffing resulted in only triage categories of 1 (critical) or 2 (emergent-rush) patients being seen by a physician. Other patients were offered Urgent Care appointments for the same or the following day.

The violation(s) has caused or is likely to cause, serious injury or death to the patient(s).

Event ID:Z8QR11

8/14/2008  2:09:11PM

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.