The following reflects the findings of the Department of Public Health during the investigation of complaint.

Representing the Department of Public Health:

Definitions:
CEO = Chief Executive Officer  
DCS = Director of Clinical Services  
RN = Registered Nurse  
LN = Licensed Nurse  
MHT =  
MAR = Medication administration record  
PRN = as needed  
A/R = Assessment and referral  
EMS = emergency medical system  
P&P = policy and procedure  
QAPI = quality assurance performance improvement  
MG. = milligrams  
CC = cubic centimeters  

Health and Safety Code 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
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(Provider/Supplier/CLIA) Identification Number: 054087

Date Survey Completed: 02/29/2008

**NAME OF PROVIDER OR SUPPLIER**
SIERRA VISTA HOSPITAL, INC.

**STREET ADDRESS, CITY, STATE, ZIP CODE**
8001 BRUCEVILLE ROAD, SACRAMENTO, CA 95823 SACRAMENTO COUNTY

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFIX TAG</td>
<td>(EACH DEFICIENCY MUST BE PRECEDEED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>PREFIX TAG</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td></td>
</tr>
<tr>
<td>Continued From page 1</td>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health and Safety Code 1280.1(c) For purposes of this section, &quot;immediate jeopardy&quot; 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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>71213. Psychiatric Nursing Srv General Requirements (a) Written policies and procedures shall be developed and maintained by the director of nursing in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.</td>
<td>Based on staff interview, clinical record review and review of policies and procedures (P&amp;P) the facility failed to develop and/or implement P&amp;Ps related to ongoing nursing assessments, P&amp;Ps for physician notification and P&amp;Ps for provision of care for patients needing medical devices.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. The facility failed to have P&amp;Ps for ongoing assessments of patients with medical symptoms such as [redacted]. On</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


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

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.
Continued From page 2

The nursing staff failed to assess Patient 1's complaint of **adequately. On ** the nursing staff failed to assess Patient 1, after the patient was found on the floor with a change of condition to ** failed to notify a physician of the change in condition.

2. The facility had no P&P that addressed care for patients needing medical devices. The nurse failed to obtain a ** device after Patient 1 informed the LN that needed ** at night for ** problems. The device is usually prescribed by a physician to treat **.

3. The facility failed to have a P&P for notification of a physician and the circumstances which would require physician notification. On ** p.m., the nursing staff failed to notify Patient 1's physician of ** complaint ** The LN failed to notify Patient 1's physician that ** needed ** night for **. On ** the nursing staff failed to notify Patient 1's physician that Patient 1 was **. Patient 1 was **.

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.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
054087

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

DATE SURVEY COMPLETED
02/29/2008

MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

NAME OF PROVIDER OR SUPPLIER
SIERRA VISTA HOSPITAL, INC.

STREET ADDRESS, CITY, STATE, ZIP CODE
8001 BRUCEVILLE ROAD, SACRAMENTO, CA 95823 SACRAMENTO COUNTY

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(Continued From page 3)

The nurse medicated Patient 1 with

Patient 1 was found in room unresponsive and staff was unable to obtain vital signs. and 911 called. Patient 1 was transferred to the emergency room of a general acute care hospital where expired.

These deficient practices of staff's inadequate assessments of Patient 1's medical conditions, Patient 1 not receiving the necessary medical equipment and staff not notifying the physician of Patient 1's critical medical condition information presented an immediate risk to patients' safety. An Immediate Jeopardy (IJ) was called on . The facility submitted an acceptable interim Plan of Correction (POC) on at 6:00 p.m., after final acceptable POC was implemented by the facility.

Findings:

The clinical record review showed an Intake Form dated indicating Patient 1 was a "walk-in assessment" admitted to the hospital, for . The patient's indicated Patient 1 was admission physician.

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


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

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.

State-2567 4 of 13
Continued From page 4

orders indicated Patient 1 had The orders contained telephone dated give upon admission and for:

1).

2).

3).

Review of the Medication Administration Record (MAR) indicated:

Review of the initial Integrated Nursing Screening Part II (face-to-face) assessment, completed by a RN (Registered Nurse, RN A) on indicated that Patient 1 was who walked into the hospital on accompanied by Patient 1 was noted the nursing assessment. The vital signs were documented on the Part II assessment as follows:

In the section "review of systems," RN A documented the following treatment plan issues for Patient 1:
Patient 1 reported . The RN noted the patient took . The RN indicated on the form that the plan issue. In the , the nurse documented that Patient 1 had .

The assessment comments section did not indicate that a physician was notified about the Patient 1.

Review of physician orders showed no orders for Patient 1. There was no indication in the physician orders, history and physical, physician progress notes, or nursing notes that the physician was aware of Patient 1 . There was no documentation in the record that Patient 1 was assessed to determine if .

On , RN A confirmed in an interview that she performed the initial face-to-face assessment (part II) of Patient 1 completed on . The RN stated that as a part of her duties she performed admission assessments of patients upon arrival to the unit. She stated that she "just followed the form" in the

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.
admission packet when assessing patients. When
patients answered yes to any questions, then she
developed a plan of care for that particular problem.
She recalled Patient 1’s arrival to the B unit on
. The RN stated that Patient A was a
The patient told her
confirmed that Patient 1 complained
The RN stated she did not ask any more
questions regarding because Patient
She documented it because she “just
followed the form.” The RN checked the clinical
record and confirmed that she did not initiate the
a treatment plan issue. She was not
sure of the reason. RN A confirmed she did not
notify the physician of the because the

RN A stated that Patient A told her that needed
The patient told the RN was at
home and would tell to bring it in the
next day. When asked what the plan was for the
upcoming night, the RN stated that she developed
a care plan indicating the patient needed
but she did not ensure Patient 1 had
She stated she did not think the patient was going
to die. (The patient expired on after staff
SIERRA VISTA HOSPITAL, INC.

8001 BRUCEVILLE ROAD, SACRAMENTO, CA 95823  SACRAMENTO COUNTY

8 of 13

continued from page 7

found the patient unresponsive in room on 05/07/2008 The RN stated that this facility had no capability to provide needed to go to another facility. She also stated that she was not concerned about patients needing instead of she would maybe call a physician to obtain orders for . The RN confirmed that she did not notify a physician on that Patient 1 needed .

The clinical record review showed on at a physician performed a history and physical (H&P) for Patient 1. The physician documented Patient 1’s past medical history included and that medications. The physician noted the patient claimed has been for . The physician noted the patient did not complain of any pain at the time of the H&P. The physician noted Patient 1’s were and according to the nursing staff, the patient had received a dose of a . There was no indication that the physician was aware of the complaint on admission or the need for .

On the physician confirmed in an interview that he had no knowledge that Patient 1 complained of to the RN on or that the patient needed at night. The physician stated that the...
Continued From page 8

Nursing assessment was not available for review when he performed the H&P. If he knew that Patient 1 needed [REDACTED] he would have made sure that the patient had it. The physician stated that if the nurse had called him when Patient 1 complained of [REDACTED] he would have most likely ordered Patient 1 sent to the ER (Emergency Room) for evaluation. The physician stated that he was on-call for the night and he had not received calls from nursing staff regarding Patient 1.

Review of interdisciplinary progress notes showed on [REDACTED] a LN (licensed nurse) noted that MHT (Mental Health Technician) found Patient 1 [REDACTED] and called in the nurse. The note indicated the patient stated [REDACTED]. The nurse noted two male MHTs from D hall (a different unit) "got pt (patient) to [REDACTED]. Pt was [REDACTED] RN medicated pt [REDACTED] The note indicated a RN was sitting at the bedside with the patient. At [REDACTED] a note indicated the RN was able to obtain vital signs.

On [REDACTED] the night shift RN documented "At [REDACTED] summoned to room, found pt to be in bed, [REDACTED] with several staff at bedside. Pt medicated [REDACTED] The vital signs were documented [REDACTED] with repeat of vital signs [REDACTED]. The RN noted Patient 1 reported feeling..."
A. BUILDING PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

054087

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

DATE SURVEY COMPLETED

02/29/2008

NAME OF PROVIDER OR SUPPLIER

SIERRA VISTA HOSPITAL, INC.

STREET ADDRESS, CITY, STATE, ZIP CODE

8001 BRUCEVILLE ROAD, SACRAMENTO, CA 95823 SACRAMENTO COUNTY

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>X4</td>
<td>ID</td>
<td>PREFIX</td>
</tr>
</tbody>
</table>

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
</table>

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
</table>

Continued From page 9

and that the room was "darkened." The RN noted the patient appeared

The nursing notes indicated a psychiatrist was paged at 12:47 again at 12:59, and again
in an attempt to "give report" about Patient 1. At the nurse wrote,

The next note dated

MHT informed this RN that Pt had fall incident. Pt is not responsive and no Code Blue called and 911 called and responded around The note indicated Patient 1 was taken to the hospital at . At a note indicated a message was left on a physician's voice mail with no return call.

A late entry for by the night RN indicated that Patient 1 used that the patient was noted in , and that MHT was placed "outside pt door to assist pt." The RN noted that she asked the patient about the and the patient stated, The note indicated awaiting return call from the physician. On a note indicated that a nurse called the ER and was notified Patient 1 passed away.

an interview with the day


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

TITe

(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.
Continued From page 10

shift RN for was conducted. The RN stated that on he arrived to the A/B unit a little before he checked his assignments. The RN noticed MHT standing in the corridor across from the night shift. The RN went to the nursing station, then to the other end of the hallway to clock-in as the near computer was not working. The RN stated he clocked in before and returned to where the MHT was still standing outside Patient 1’s room. The lights were off in the room. The RN stated that he walked into Patient 1’s room to check on the patient. Patient 1 did not respond to him. The RN then immediately turned on the light and found Patient 1 lying on diagonally. The RN yelled out for nurse arrived to the room, they placed Patient 1 on the floor and where the MHT was. The RN stated Patient 1’s . Shortly after other staff arrived and resuscitation measures were performed until EMS arrived (approximately 15-20 minutes.) The RN stated there was no in Patient 1’s room.

Review of the facility P&Ps with the DCS on showed the facility had no P&P available to nursing staff for ongoing assessments of patients presenting to the facility with medical symptoms such as and/or . There was no P&P that addressed patient care for...
Continued From page 11

There was no P&P that addressed process for notification of physician and when and under what circumstances the physician needed to be notified. There was no P&P directing staff on what to do if a physician does not respond timely to calls from staff.

On [redacted], the DCS stated the facility was investigating and identified the care issues related to Patient 1. The DCS stated the investigation was not ready to be presented and there were no corrective actions implemented to ensure other patients were not harmed as a result of repeat failures. The DCS confirmed that Patient 1 was not assessed when [redacted] complained of [redacted] on admission. There was no P&P in place that addressed ongoing nursing assessments of patients with medical symptoms. The DCS confirmed [redacted] was not obtained for Patient 1 and stated there was no P&P for obtaining medical equipment. The DCS confirmed no physician was contacted on [redacted] regarding Patient 1 and that the psychiatrist on call did not respond to the page as documented in the nursing notes. The DCS stated that the nurses should have tried alternative numbers on the call schedule and then call the Medical Director. That did not occur. He stated the facility had no P&P to direct staff on when and under what circumstances to notify a physician.

These deficient practices of staff’s inadequate assessments of Patient 1’s medical conditions, Patient 1 not receiving the necessary medical equipment and not being assessed when symptoms were noted, resulted in a potential harm to Patient 1.
Continued From page 12

equipment and staff not notifying the physician of Patient 1’s critical medical condition information caused, or was likely to cause, serious injury or death to the patient.