## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

![050324](image)

**Statement of Deficiencies and Plan of Correction**

**Date Survey Completed:**

![08/30/2007](image)

### Name of Provider or Supplier

**Scripps Memorial Hospital - La Jolla**

**Street Address, City, State, Zip Code:**

9888 Genesee Avenue, La Jolla, CA 92037 San Diego County

### Summary Statement of Deficiencies

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

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
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<tbody>
<tr>
<td>E1947 T22 DIV1 CH1 ART 70707(b)(2)</td>
<td>Patients' Rights</td>
<td></td>
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(b) A list of these patients' rights shall be posted in both Spanish and English in appropriate places within the hospital so that such rights may be read by patients. This list shall include but not limited to the patients' rights to:

1. Considerate and respectful care.

### Deficiency Constituting Immediate Jeopardy

1280 1(a) HSC Section 1280

If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Sections 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 ($25,000) per violation.

1280 1 (c) HSC Section 1280

For purposes of the 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.

### Laboratorv Director's or Provider/Supplier Representative's Signature

**Event ID:** BM3P11  
**Date:** 3/18/2008 12:37:15PM

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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E1969 T22 DIV5 CH1 ART7-70707(d) Patients' Rights

(d) All hospital personnel shall observe these patients' rights.

This REGULATION: is not met as evidenced by:

Based on multiple staff interviews and medical record review, the facility acting through its' hospital personnel failed to protect 1 of 1 patients from verbal and physical abuse. Patient 1 had undergone an invasive cardiac procedure, and was lying on a gurney awaiting transfer to an intensive care unit, when the physician who had performed the invasive procedure proceeded to verbally and physically abuse the patient.

Findings:

Patient 1 was admitted to the facility through the Emergency Department on 8/23/07 with diagnoses that included chest pain, and history of pacemaker implantation per the discharge summary. Per the same summary, on 8/24/07 Patient 1 underwent a, "Diagnostic angiogram performed by Physician A.....During the procedure the patient became extremely combative and aggressive...He was given additional doses of fentanyl along with Haldol to calm the patient down. These did not work. The patient was transferred to the intensive care unit...." The patient was discharged home from the facility on 8/26/07.

On 8/29/07 at 2:00 P.M., Employee 1 was
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Interviewed by Department staff. Employee 1 said that staff from the cardiovascular laboratory notified facility management of an incident that occurred on 8/24/07, where Physician A allegedly verbally and physically abused a patient during and after an invasive cardiac procedure.

On 8/29/07 at 3:15 P.M., the medical record of Patient A was reviewed. A handwritten note written by Physician A on 8/24/07 at 5:00 P.M., entitled "Post Cath. Progress Notes" revealed that Physician A underwent a PTCA [percutaneous transluminal coronary angioplasty]. There was no documentation on this record that the patient had displayed combative behavior. A typed dictated note by Physician A, done on 8/24/07 at 5:58 P.M. noted, "Throughout the procedure, patient was extremely agitated despite 500 mg [milligrams] of fentanyl, 7 mg of Versed, given patient's high tolerance for these drugs..."

The document entitled, "Custom Forms: Procedure" dated 8/24/07 detailed the multiple medications administered to the patient during the invasive cardiovascular procedure. The same document also detailed the patient's complaints, "4:28:01 PM Pt awake screaming c/o chest pain moving all extremeties [sic] at random, will not stop moving...4:33:13 PM Pt awake screaming, requiring 5 staff members to restrain pt, will answer questions c/o chest pain, but will scream...4:42:47 PM Screaming...5:06:26 PM IV restart rt arm, pt remains screaming, restless..."

On 8/29/07 at 4:15 P.M., Employee 2 was interviewed by Department staff. Employee 2 was...
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present during and after the invasive cardiovascular procedure involving Patient A on 8/24/07. Employee 2 said that midway through the procedure, the patient became agitated, and that he [Employee 2] tried to talk with the patient and calm him down. Employee 2 said that the patient was moving his legs, trying to sit up and trying to reach up over the sterile drape and onto the area where the catheter was being inserted. Employee 2 said that during the procedure the patient was yelling, "At the top of his lungs." Employee 2 said that the physician made multiple physical attempts to control the patient during the procedure, which included squeezing the patient's hand, "chopping like" blows to the patient's abdomen [at the diaphragm level]. Also Employee 2 stated that Physician A used the tip of his elbow to hit Patient A on the forehead in attempts to get the patient to lie down during the procedure. Employee 2 said that at one point during the procedure, Employee 2 had his hand under the sterile drapes and on the patient's leg, to keep the leg from moving. Employee 2 said that Physician A started hitting the patient's leg, but the physician was actually hitting Employee 2's hand, "With a substantial amount of force."

Employee 2 said that after the procedure was completed, Physician A left the cardiovascular laboratory and the patient was moved onto a gurney. Employee 2 said that both side rails on the gurney were pulled up and 3 other staff persons were immediately adjacent to the patient on the gurney and monitoring the patient's condition. Employee 2 said that Physician A returned and spoke loudly to Patient A and said, "You are an
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**Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)**

**Patient 1**

- **Event ID:** BM3P11  
  **Date:** 3/18/2008 12:37:15PM

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Animal.* Employee 2 then demonstrated how Physician A grabbed the patient's nose using his index and middle finger, pushing the palm of his hand down onto the patient's mouth, and forcefully twisting the patient's nose. Employee 2 said that the patient's nose became bluish in color. Employee 2 then demonstrated how Physician A grabbed Patient A’s left upper inner arm, leaving indentations on the patient's skin.

On 8/29/07 at 4:55 P.M., Employee 3 was interviewed by Department staff. Employee 3 said she was called in to the procedure room on 8/24/07 because of the patient's agitation. Employee 3 said she went to the head of the bed, and attempted to calm the patient down. Employee 3 said that the physician refused to allow staff to call for anesthesia to assist with the procedure. Employee 3 said that after the procedure, and while the patient was on the gurney, the physician, "grabbed and twisted the patient's nose. Employee 3 said that Physician A pushed his index finger into the patient's bicep while the patient was on the gurney. Employee 3 said that she had never seen the physician so mad and that the physician's "volatility was not new."

On 8/30/07 at 1:40 P.M., Department staff met with facility administrative staff and informed them that Immediate Jeopardy had been called at the facility. The Immediate Jeopardy determination was made because initial interviews with facility staff on 8/29/07 corroborated the allegations that Physician A verbally and physically abused Patient 1 after the invasive procedure had been completed and while

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the patient was lying on the gurney.

The Immediate Jeopardy was abated on 8/30/07 at 6:10 P.M., after the Department had received a plan of correction from facility administrative staff.

As a result of the determination of Immediate Jeopardy, the Center for Medicare Services [CMS] directed the Department to initiate a complaint validation survey. This survey was started on 8/30/07 at 2:00 P.M., while Immediate Jeopardy was still in place.