STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDENSUPPLIES (DENTIFICATION NUM 050115			(CZ) MULTI A. SUILDIN B. WING	PLE CONSTRUCTION	COMPLETED			
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	ROMDER OR SUPPLIER R MEDICAL CENTER		STREET ADDRESS, CI			POLINEY		
PALUMA	K MEDICAL CENTER	Ī	335 E, VALLET PA	KNWAT, E	ESCONDIDO, CA 82025 SAN DIEGO	COUNTY		
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	The following reflects to		artment			010 ***		
	of Public Health during a complaint/adverse investigation visit: Complaint Intake Number: CA00213140 - Substantiated Representing the Department of Public Health: 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. 70215 Planning and Implementing Patient Care. (a) (3) (b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnoses, planning,				・ (本) (2) (4)	• •		
					LICENSING & CERTIF	ICATION		
				i	SAN DECO NORTH DIST	RICT OFFICE		
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				Ī	70215 Planning and Implementing Pat	lient Care		
	intervention, evaluati require, patient advoc a registered nurse at th	cacy, and shall be in time of admission.	cumstances initiated by		The nurse to patient ratio in the critica units will be 1: 2 or fewer at all times.	l care		
	70217 Nursing Service			I	Person Responsible; Nurse Director		12.29.09	
		ed nurse-to-patient			- 5,550 (Teaponaible, Nurae Director		12.23.03	
	critical care unit shall							
	"Critical care unit" means a nursing unit of as general acute care hospital which provides one of			ľ				
	the following services burn center, a coronary							
	DUITH COMMIT A CONTRACT	COLE POLAICE, RIL SCI	10					
Event ID:	GZ3P11	<u> </u>	5/26/2010	3:38:2	2PM			
	RY DIRECTOR'S OR PROVIDE		TATIVE'S SIGNATUR	RE	TITLE		(X6) DATE	
- Χ Υ//	Son alassu	10.			Chief Nursing Officer		6.15.10	

Any difficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be accused from correcting providing it is determined that other safeguards provide sufficient protection to the petients. 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

AND PLAN OF CORRECTION DENTIFI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060115	A	2) MUI BURLD WING		(C3) DATE SURVEY COMPLETED 01/25/2010	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE	ZIP CODE		
	R MEDICAL CENTER	I			, ESCONDIDO, CA 92025 SAN DIEGO COUI	NTY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	IC PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORREFERENCED TO THE APPROPRIATE DEFIC	R055-	(X5) COMPLETE DATE
	1 ' '	or an intensive care nev e ratio shall be 1 regis					
	capacity may be use that designated on to the Director and fluctuations justify, the	f a facility's total licensed d for a classification other he license. Upon application a showing that sea he Director may grant the percent of the beds for	than on to sonal use		The RN assigned to primary care for this patient was interviewed at the time of the f Person Responsible; Nurse Director	fall.	12.29.09
	This Rule is not met as	evidenced by:			The RN in this instance was aware of her responsibility to provide for the safety of he patient relative to fall prevention. Person Responsible; Nurse Director	er	12.29.09
	[ICU] fell out of her became disconnected from her oxygen so access which had medications for bloowas on the floor in thour before the ICU spatient's room was of had been pulled arouvisible to staff. The monitor, assess and A resulted in the patarrest, severe brain if and ultimately the with A died the day after her	ent in an intensive care bed to the floor. Patie of from her cardiac mource and from her intrave been delivering vasoed pressure control. Patie this condition for more that staff found her. The door to closed, and the privacy out of the ICU state intervene on behalf of Patient suffering prolonged can injury, progressive organ for that was of life support. Par fall from her bed in ICU.	ant A anitor, anous active ant A an an bothe aurtain s not aff to atient ardiac allure				
Event ID	<u> </u>		 6/2010	3:35	:22PM		<u></u>
		ER/SUPPLIER REPRESENTATIVE		0.00	TITLE		(X6) DATE

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Continued From page 2 medical surgical patients in 4 of the ICU designated beds on the same 12 bed unit where Patient A was located. One registered nurse was assigned to provide care for the 4 medical/surgical patients. The Department was unaware of the facility's practice to place lower acuity patients in ICU designated beds and to staff these patients at a lesser level. The nurse to patient ratio in the critical care units (CCU) will be 1: 2 or fewer at all times.	
PALOMAR MEDICAL CENTER SSS E. VALLEY PARKWAY, ESCONDIDO, CA 92025 SAN DIEGO COUNTY	25/2010
(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) Continued From page 2 medical surgical patients in 4 of the ICU designated beds on the same 12 bed unit where Patient A was located. One registered nurse was assigned to provide care for the 4 medical/surgical patients. The Department was unaware of the facility's practice to place lower acuity patients in ICU designated beds and to staff these patients at a lesser level. Findings: The nurse to patient ratio in the critical care units (CCU) will be 1: 2 or fewer at all times. Person Responsible; Nurse Director 1.1.1	_
medical surgical patients in 4 of the ICU designated beds on the same 12 bed unit where Patient A was located. One registered nurse was assigned to provide care for the 4 medical/surgical patients. The Department was unaware of the facility's practice to place lower acuity patients in ICU designated beds and to staff these patients at a lesser level. The nurse to patient ratio in the critical care units (CCU) will be 1: 2 or fewer at all times. Person Responsible; Nurse Director 1.1:	(X5) COMPLETE DATE
and colitis according to the Patient Information sheet. According to the physician notes Patient A had bilateral tower lobe infiltrates (a fluid collection in the lungs) and a clinical suspicion of H1N1 influenza. Patient A was admitted to the medical floor on isolation from the emergency room, where she had been noted to have some confusion with decreased level of consciousness, according to the emergency room notes On 12/26/09 at 6:12 p.m., according to the Rapid Response Team record, Patient A was transferred to the Intensive Care Unit (ICU) for closer observation due to severe respiratory distress. While in the ICU, Patient A was placed on cardiac and pulse oximetry monitoring (a non-invasive optical measurement system to determine oxygen levels) all connected to alarms as well as an IV	1.15.10
pump infusing Levophed (a vasoactive medication used for blood pressure control), intermittent BiPaP oxygen (bi-level positive airway pressure, a noninvasive means of assisting oxygen and	
Event ID:GZ3P11 5/26/2010 3:38:22PM ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6)	

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA EDENTIFICATION NUMBER: 050115			(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP A. BUILDING B. WING 0			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRESS.	CITY, STATE	, ZIP CODE		_
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL.	IIO PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD) REFERENCED TO THE APPROPRIATE D	BE CROSS-	(XS) COMPLETE DATE
· · · · ·	Continued From page	3			 		
	ventilation) also connect Patient A was identifulation the facility's computed ated 12/26/09 and the physician order reason for the order documented as due pull/remove lines/tul attempting to get out of On 12/29/09 Patient A	cted to alarms. fied as high risk if terized nursing do 12/27/09. On 12/27 ed soft wrist res of the wrist res to the patient at bes/equipment/dress bed. I fell on the floor in onnected from to ous line Levophed detivery system, t was found by a complete arrest a ode Blue record. tat signs by Licens	front of her he cardiac medication, and pulse respiratory of 6:01 p.m., The last ed Nurse 1		The critical care staff have been orient use of the overview function of the car monitoring system to provide alert/alar notification when they are providing ca another patient in the CCU. Person Responsible; Nurse Director The critical care staff have been re-ed Procedure, "Fall Prevention and Mana Person Responsible; Nurse Director The critical care staff have been orient maintain the door to the room open or patients to improve alert/alarm audibilit Person Responsible; Nurse Director The critical care staff have been orient maintain the privacy curtain open to imdirect observation of the patients.	diac m are to ucated on gement". ted to all ty.	4.30.10 4.30.10 4.15.10
	4:30 p.m. on 12/29/09. On 12/31/09 at 11:45 responding to Patient interviewed. According the arrived at Patient was pulled so that the staff passing by the resource nurse, Patient the had been inconting pump administering the side of the bed and the patient. The oxygen The patient was cold establishing an intraver.	It A's arrest on of the resource of the resource of the patient was refer to the properties. According to the room. According to the the room of the resource was lying and there was so	12/29/09 was nurse, when vacy curtain of visible to ing to the floor, where IV and IV the opposite iched to the on the bed.		Person Responsible; Nurse Director Audits documenting use of the overvie open doors and open privacy curtains initiated when the orientation was com are ongoing. Person Responsible; Nurse Director	were	4.30.10
Event ID:	 G Z 3P11		5/26/2010	3:38):22PM		
	Y DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESE		URF	TITLE		(X6) DATE

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MANE OF PROVIDER OR SUPPLIER STREET ACROSS, CITY, STATE, EXP DOOD SOS E. VALLEY PARKWAY, ESCONDIDO, CA 92025 SAN DIEGO COUNTY SOS E. VALLEY PARKWAY, ESCONDIDO, CA 92025 SAN DIEGO COUNTY PRETY SACH DEPOSITY MATT RE PRESENCES OF FULL RESULATION OR USE GENERAL PROVIDER SACH DEPOSITY FULL RESULATION OR USE GENERAL PROVIDER SACH DEPOSITION ACCORDING TO RT 1, Pasient A was used a approximately 6:00 p.m. on 12/29/09, he went looking for respiratory equipment in ICU. RT 1 found Patient A lying on the floor. According to RT 1, Patient A was lying on the floor between the glass door to the nutrity station and her bed. The door to the patient aroom was closed, and the privacy outsin had been pulled so that the patient was not visible. According to RT 1, Patient A was not isolation, unstable, and had fatigle of a stempts to ween her oxygen. RT 2 stated Patient A was on isolation, unstable, and had fatigle at stempts to ween her oxygen. RT 2 stated Patient A appeared tred with the work of breathing and that he had discussed this with LN 1 and placed Patient A on BIPAP before he left. RT 2 shared that it is difficult when medical surgical patients are housed in the ICU unit, because it decreases the number of respiratory and ICU staff evallable to the ICU patients. Licansed Nurse 1 [LN1] was interviewed on 125/10 at 2:30 pm. LN 1 was the care provider for Patient A on 12/29/09 from 7:00 a.m. to 7:00 pm. According to LN 1 she checked the patient's vital signs every hard hour, as Patient A was on Levophed. LN 1 stated she did not recall hearing Event ID-C23P11 STATES AND A PROVIDERSUPPLIER REPRESENTATIVES SIGNATURE TILE (K6) DATE	AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION MUMBE	R:	(X2) MULT	TIPLE CONSTRUCTION	(C3) DATE BURVEY COMPLETED			
PALOMAR MEDICAL CENTER SSS E VALLEY PARKWAY, ESCONDIDO, CA 20225 SAN DIFGO COUNTY PRIPTIX PRODUCTION OF THE COMMITTIE RECEDED BY FULL REGULATORY OR LISC GENTERING METOGRANDON Continued From page 4 On 1/25/10 at 2:00 p.m., RT 1 was interviewed. According to RT 1, he was working the emergency room that day and at approximately 6:00 p.m. on 12/29/09, he went looking for respiratory equipment in ICU. RT 1 found Patient A lying on the floor. According to RT 1, Patient A was lying on the floor. According to RT 1, Patient A was lying on the floor between the glass door to the nutriting station and her bed. The door to the patients room was closed, and the privacy curtain had been pulled so that the patient was not visible. According to RT 1, Patient A was on isolation, unstable, and had failed at attempts to warn her coxygen. RT 2 stated Patient A was on isolation, unstable, and had failed at attempts to warn her coxygen. RT 2 stated Patient A was on isolation, unstable, and had failed at attempts to warn her coxygen. RT 2 stated Patient A on BIPaP before he left. RT 2 shared that it is difficult when medical surgical patients are housed in the ICU unit, because it decreases the number of respiratory and ICU staff evallable to the ICU patients. Licensed Nurse 1 [LN1] was interviewed on 1/25/10 at 2:30 pm. LN 1 was the care provider for Patient A on 12/29/09 from 7:00 am. to 7:00 pm. According to LN 1 she checked the patient's visit signs every half hour, as Patient A was on Levophed. LN 1 stated she did not recall hearing. Event IDC22911 526/2010 3:38:2PM			05 0115		B. WING		01/2	5/2010		
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		at 2:30 pm. LN 1 was A on 12/29/09 fro According to LN 1 s signs every half h	s the care provider to m 7:00 a.m. to he checked the patie our, as Patient A	r Patient 7:00 p.m. nt's vital was on						
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· · · · -	MEDICAL CENTER		•	RESS, CITY, STATE, ZIP CODE LEY PARKWAY, ESCONDIDO, CA 92025 SAN DIEGO COUNTY					
041 ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	3	10	PROVIDER'S PLAN OF CORRECT	TION	QC5)		
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ins	REGULATORTOR	SC IDENTIFTING SW-CHEM	illow)	TAG	REFERENCED TO THE APPROPRIATE (DEFICIENCI /	DATE		
	Continued From page 5 anything in report related to a history of confusion in Patient A or that Patient A might be a fall risk. LN 1 stated that Patient A was restless, and that she [LN 1] had to remind the patient not to get out of bed to use the bathroom as she was not stable. Patient A was given the bedpan by LN 1, but the patient was unsuccessful. According to LN 1, the last time she recalled seeing Patient A was at approximately 4:30 to 4:40 p.m. The last documented set of vital signs LN 1 recorded on the nursing flow sheet was at 4:30 p.m. on 12/29/09. According to the Code Blue Record, on 12/29/09 facility staff started resuscitative measures on Patient A at 6:01 p.m. Per the same record, twenty-two [22] minutes of resuscitative measures elapsed before staff could recover a pulse in Patient A. According to the physician note from Physician X, who responded to the code, Patient A was lying on the ground with stool next to her, all leads were off, line[s] pulled out, and she was unresponsive. When monitor leads were reapplied Patient A was noted to be in asystole (cardiac arrest or absence of a heart beat). On 12/30/09, Physician X requested a critical care consult by Physician Y. Physician Y's consult was reviewed. According to Physician Y's consult dated 12/30/09, Patient A had developed progressive organ dysfunction, respiratory failure, renal failure, evidence of an acute myocardial infarction, homodynamic embarrassment, and severe metabolic acidosis (PH imbalance in which the body has accumulated too much acid and does not have enough bicarbonate to effectively neutralize								
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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				A BUILDI	NG	30			
		050115		B. WING		01/25/2010			
NAME OF PRO	MOER OR SUPPLIER	<u> </u>	STREET ADDRESS.	CITY, STATE	.7IP CODE				
	MEDICAL CENTER		555 E. VALLEY I	EY PARKWAY, ESCONDIDO, CA 92025 SAN DIEGO COUNTY					
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(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES			10 Prefix	PROVIDER'S PLAN OF CORRECT GEACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE		
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			,				<u> </u>		
	Continued From page 6								
	the effects of the	•							
	suffered a cardiac arrest last evening (12/29/09)								
	with a prolonged res								
	evidence of severe	•	•						
	oxygen in the tissue or organs) injury if not outright brain death. According to the note, Physician Y indicated the family had been informed that Patient A had probably suffered irretrievable damage, and it was unlikely she would have any meaningful recovery on any level.								
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I									
					ì		Į ,		
	Patient A was disco	onnected from life	support on						
1	12/30/09 and expired t	he same day.	J						
	Review of the staffin	no sheets for 1 <i>212</i> 9	MD9 revealed		The nurse to patient ratio in the critical	d care units			
I	that four [4] beds	•			will be 1: 2 or fewer at all times.				
	Patient A was located				Person Responsible; Nurse Director		1.15.10		
	surgical patients being	•	-		1				
	to 5 patient ratio.								
	a.m. to 7:00 p.m.) 1	for this unit in th	e ICU was						
	reviewed with the nu	ursing manager on	1/25/09. A						
	charge nurse in the !	ICU, present during	the staffing						
	review, stated that the	• • •							
	medical surgical pati	-							
	the ICU, whenever th	•			1				
	pod" in the ICU. T	*			Ì				
	Department that low	• •							
I .	in the ICU beds, and providing care patients at a lower staffing ratio, than the ICU								
	haments at a tower 2(9)	migrado, man mero	U TAUU.						
	Patients are admitte	ed to intensive ca	re units in						
	order to ensure th				1				
	closely monitored by	facility staff. Patier	it A was in						
	isolation with the								
	audible alarms from ins	side the room. Furth	er, the						
Event ID:G			5/26/2010	3:38:	:22PM				

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 discloseble 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 discloseble 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 OSD115			(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		OCH DATE SURVEY COMPLETED 01/25/2010				
			-	D. TWING		0029	WZUTU		
NAME OF PR	OWIGER OR SUPPLIER		STREET ADDRESS,	CITY, STATE	, ZIP CODE				
PALOMAR	R MEDICAL CENTER		566 E. VALLEY F	Y PARKWAY, ESCONDIDO, CA 92025 SAN DIEGO COUNTY					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS- TAG REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETE DATE		
	Continued From page curtain was closed, visible to staff in the faiture to ensure monitoring of a pati respiratory compromitisk, was on externative respiratory status, intravenous medicati pressure resulted in a a deficiency that has serious injury or deal constitutes an immeaning of Health and (c). This facility failed to described above that serious injury or dealt constitutes an immeaning of Health 1280.1(c).	so that the patie immediate area. ongoing assessient who was in se, a documente all monitors of her and who was ion to stabilize a patient fall and do caused, or is like the to the patient, a nediate jeopardy of prevent the deficie caused, or is like the to the patient, are diate jeopardy	ent was not. The facility's sment and a state of d high fall cardiac and a receiving her blood eath. This is ely to cause and therefore within the ction 1280.1 ency (ies) as y to cause, and therefore within the within the course, and therefore within the		This page has bee intentionally left bla	n			
Event ID:0	3Z3P11		5/26/2010	3:38:					

Any deficiency statement ending with an estertak (*) 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 data these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

State-2567

(X6) DATE

TITLE