| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050534 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______ | (X3) DATE SURVEY COMPLETED 04/02/2018 |
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| | The following reflects the findings of the Department of Public Health during an inspection visit:<br><br>Complaint Intake Number:<br>CA00552371 - Substantiated<br><br>Representing the Department of Public Health:<br>Surveyor ID # 3134<br><br>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.<br><br>Health and Safety Code Section 1280.3(g): 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.<br><br>A014 HSC Section 1280.3(g):<br><br>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.<br><br>Health and Safety Code section 1280. (3) (a) Commencing on the effective date of the regulations adopted pursuant to this section, the director may assess an administrative | | **The plan of correction is prepared in compliance with federal regulations and is intended as JFK Memorial Hospital (the "hospital") credible evidence of compliance. The submission of the plan of correction is not an admission by the facility that it agrees that the citations are correct or that it violated the law.**<br><br>**Organization Minutes:**<br>The confidential and privileged minutes are being retained at the facility for agency review and verification if required.<br><br>**Response**<br>This case was immediately reported to the Hospital and Medical Staff Quality Review Committee's for further review and action at the time that this occurred. The hospital staff and the Emergency Department physician made every effort to contact the surgeon "on-call" at the time of this event and documented each attempt in the medical record. The Emergency Department physician called every credentialed and privileged surgeon on staff to expedite the treatment for this patient and documented his attempts in the medical record.<br><br>JFK Memorial Hospital had the appropriate physical resources and personnel to meet the needs of the patients at the time of this event. Medical Staff Services had a policy and procedure in place for physician on-call back up, and the Rules and Regulations required the physician to respond within 30 minutes if requested by the Emergency Department physician. It is the expectation of the physician that is taking call to be available upon | |

Event ID:ENQQ11 6/12/2018 4:28:39PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE CEO (X6) DATE 6/27/18

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 16

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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| | penalty against a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250for a deficiency constituting an immediate jeopardy violation as determined by the department up to a maximum of seventy-five thousand dollars ($75,000) for the first administrative penalty, up to one hundred thousand dollars ($100,000) for the second subsequent administrative penalty, and up to one hundred twenty-five thousand dollars ($125,000) for the third and every subsequent violation. An administrative penalty issued after three years from the date of the last issued immediate jeopardy violation shall be considered a first administrative penalty so long as the facility has not received additional immediate jeopardy violations and is found by the department to be in substantial compliance with all state and federal licensing laws and regulations. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section.<br><br>42 C.F.R. 489.20 Basic Commitments<br>The provider agrees to the following:<br>(r) In the case of a hospital as defined in 489.24 (b) (including both the transferring and receiving hospitals), to maintain-<br>(2) An on-call list of physicians who are on the hospital's medical staff or who have privileges at the hospital, or who are on staff or have privileges at another hospital participating in a formal community call plan, in accordance with 489.24 (j) (2) (iii), available to provide treatment | | notification and respond within 30 minutes of an emergent request as per the Medical Staff Rules and Regulations. This physician did not meet this requirement.<br><br>The Medical Staff On-Call Panel policy has been revised, requiring the on-call emergency panel physician to have an approved back-up physician for circumstances beyond the panel member's control and anytime that the panel member cannot respond to the Emergency Department within 30 minutes.<br><br>JFK Memorial Hospital takes patient safety very seriously and feels that this event is an isolated occurrence involving one surgeon who did not adhere to Medical Staff Rules and Regulations that requires the on call panel physician to respond to the Emergency Department within 30 minutes.<br><br>**Policy & Procedures:**<br>The Chief of Staff, Director of Medical Staff Services and the Director of Clinical Quality Improvement reviewed the Medical Staff Rules and Regulations and the Medical Staff Policy and Procedure for Emergency Backup Call Panel Schedules. The Medical Staff made revisions to these policies requiring "on call panel physician" to have an approved back-up physician for circumstances beyond the control anytime the physician cannot respond to the emergent situation within the required 30 minutes. These revisions were approved at MEC on 02/06/18 and the Governing Board on 02/15/18<br><br>**Training:**<br>All Emergency Department staff is competent and trained upon hire and re-in serviced on | 02/06/18<br>02/15/18<br><br>02/06/18 |

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| | necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under§ 489.24 in accordance with the resources available to the hospital;<br><br>42 C.F.R. 489.24 Special Responsibilities of Medicare Hospitals in Emergency Cases<br>(j) Availability of On-call Physicians<br>In accordance with the on-call list requirements specified in 489.20 (r) (2), a hospital must have written policies and procedures in place-<br>(2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to-<br>(i) Permit on-call physicians to schedule elective surgery during the time they are on call<br>(ii) Permit on-call physicians to have simultaneous on-call duties.<br><br>Title 22 of the California Code of Regulations Section 70701(a)(4) Governing Body<br>(a) The governing body shall:<br>(4) Provide appropriate physical resources and personnel required to meet the needs of the patients and shall participate in planning to meet the health needs of the community.<br><br>Title 22 of the California Code of Regulations Section 70703 (f) Organized Medical Staff<br>(f) The medical staff shall provide for the | | EMTALA regulations and Emergency Department on-call panel policy and procedure.<br><br>During the physician onboarding process the Chief of Staff and/or designee provides each physician a copy of the Medical Staff Policy and Procedure and the Medical Staff Rules and Regulations. These policies outline the requirements of the on-call physician's responsibility that include responding to the Emergency Department within 30 minutes of being called by the Emergency Department Physician or designee and having an approved back-up physician for circumstances beyond the on-call panel physicians control.<br><br>The Emergency Department staff are trained upon hire on the hospital Chain of Command policy and procedures to include writing an incident report and notifying the Administrator on Call and Chief of Staff to escalate patient safety concerns for immediate action.<br><br>**Monitoring:**<br>The Medical Director and the Nursing Director of the Emergency Department and/or designee monitors the on-call panel daily to ensure there is a noted back up surgeon and will report using the hospital Chain of Command for any surgeon that fails to respond as determined by the Emergency Department physician. Any on-call panel physician that fails to respond at the request of the Emergency Department physician and/or designee will be reported by the Emergency Department Medical Director to the Chief of Staff, Medical Staff Quality review Committee, Medical Executive Committee and the Governing Board for further action. | 12/05/17<br>02/06/18<br><br>12/05/17<br>02/06/18 |

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| | availability of staff physicians or psychologists for emergencies among the in-hospital population in the event that the attending physician or psychologist or his or her alternate is not available.<br><br>Based on interview and record review, Facility A failed to ensure on-call physician coverage was available for one patient (Patient 1) when the General Surgeon on-call did not respond timely to the ED physician's request for further evaluation in order to provide the necessary treatment to stabilize Patient 1's emergency medical condition. This failure was the direct cause of a delay in medical treatment for Patient 1, which contributed to a decline in Patient 1's emergency medical condition. Patient 1 was transported to another facility (Facility B) in critical condition and died 50 hours and 34 minutes later.<br><br>Findings:<br><br>On October 4, 2017, at 10 a.m., Survey A conducted an unannounced visit to Facility A for the investigation of one anonymous complaint regarding Patient 1.<br><br>Review of Patient 1's clinical record indicated Patient 1's treatment in Facility A's ED on September 7, 2017, was as follows:<br><br>At 1:23 p.m., Patient 1 was brought in by ambulance, with chief complaint of abdominal pain for two hours after an episode of vomiting. | | **Other Corrective Actions:**<br>The Director of Clinical Quality Improvement referred this case to the Medical Staff Quality Review Committee at the time that this event occurred.<br><br>The Chief Executive Officer reported this case to the Medical Executive Committee and the Governing Board for review and action.<br><br>**Responsible Person(s):**<br>Emergency Department Medical Director<br>Director of Emergency Services<br>Chief of staff.<br><br>**Disciplinary Action:**<br>Medical Staff members demonstrating non-compliance with corrective action will be referred for peer review in accordance with Medical Staff bylaws, as appropriate. | *12/05/17*<br>*02/06/18*<br><br>*02/06/18* |

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At 1:31 p.m., Patient 1 was assessed and triaged as moderately ill with an acuity level of 3 (acuity levels of 1-5 used in the ED to rate patient's condition with 1 being most critical and 5 least critical). The record indicated Patient 1 was a 75 year old male, alert and oriented, who lived at home with his wife. The record indicated Patient 1 had a blood pressure of 102/68 mmHg (normal 120/80-millimeters of mercury-a unit of measure) and a heart rate of 120 beats per minute (normal rate 60-100).

At 1:36 p.m., Patient 1 was seen by the ED Physician (ED MD).

At 1:53 p.m., Patient A had a CT scan (computerized tomography uses X-rays to create cross-sectional images of the body to check for injuries and abnormalities) of the abdomen and pelvis, without contrast. The CT results, interpreted by the radiologist, indicated, "Fluid seen around the liver and spleen of high attenuation. Suspicious for hemoperitoneum" (bloody fluid in the abdominal cavity).

At 1:58 p.m., a complete blood count was performed, and showed Patient 1's hemoglobin level (protein in the blood that carries oxygen to the tissues and can be used to check for evidence of internal bleeding) was 11.3 g/dl (normal value is 14.0-18.0, grams per deciliter-a unit of measure).

At 2:57 p.m., the ED Physician's Notes indicated

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the ED MD called and spoke to the General Surgeon on-call (GEN SURG 1) by phone, who was in surgery at Facility B. The record indicated GEN SURG 1 stated, "His (Patient 1's) H & H (hemoglobin and hematocrit) is stable. Without free air or any obvious solid organ injury, can manage the patient on the floor, will see the patient when he (GEN SURG 1) gets out of surgery (at Facility B)...Suspects CT findings to be other than sanguineous (bloody) in origin." The record indicated GEN SURG 1 further recommended Zosyn (a medication to treat infections), admit (Patient 1) to medicine, get serial H & H, and (GEN SURG 1) would follow the patient.

At 3:23 p.m., the Nurse's Notes indicated, "Pt (Patient 1) has extremely low BP (blood pressure). (ED MD) notified." The ED MD ordered Patient 1 to have two liters of IV fluid bolus (intravenous fluids given rapidly directly into the vein).

At 3:29 p.m., The ED Physician's Notes indicated Patient 1's condition worsened, "Called to the bedside for decreasing blood pressure now 63/50...stating abdominal pain getting worse. Review of blood pressures show trending downwards...mildly tachycardic (elevated heart rate) 105-110...on examination...has more significant diffuse tenderness (in his abdomen)."

At 3:38 p.m., Patient 1's hemoglobin level was noted to be 8.0 g/dl (a drop of 3.3 points in one

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hour and forty minutes, which, indicates blood loss).

At 3:45 p.m., the ED MD called and spoke to GEN SURG 1 a second time, to request further evaluation in order to provide treatment for Patient 1. The record indicated GEN SURG 1, "recommends contrast CT but told him the pt (Patient 1) is not stable enough at this moment...called lab for a stat H & H. Will call (GEN SURG 1) back after I receive the results."

At 3:47 p.m., the ED Physician's Notes indicated, "Per wife- pt (Patient 1) fell one month ago and since then has had intermittent abdominal pain. Was previously seen at another hospital and admitted for 2 days but the wife does not know what for."

At 3:49 p.m., the Nurse's Notes indicated, "Sepsis bundle initiated (protocol to treat septic shock symptoms), (ED MD) spoke with (GEN SURG 1) updated to pt decline in BP and CT results...Continuous observation in progress."

At 3:56 p.m., the ED Physician's Notes indicated the ED MD called and spoke to GEN SURG 1 again (a third time), and GEN SURG 1, still at Facility B, recommended, "looked at CT again but thinks it might believe [sic] a splenic laceration... (GEN SURG 1) has one more case (surgery to perform) before he can come to the ED."

At 4:10 p.m., the ED Physician's Notes indicated

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the ED MD called and spoke to a second General Surgeon (GEN SURG 2), who was not on-call, to request surgical consult for further evaluation for Patient 1. The Notes indicated "(GEN SURG 2) is unable to come to (facility A) because he is at (another facility's name) working on a case."

At 4:20 p.m., the ED Physician's Notes indicated Patient 1 had a central line (intravenous catheter placed in a large central vein-can be used to give large volumes of fluid or blood) placed in the right subclavian vein by the ED MD and Physician's Assistant.

At 4:58 p.m., Patient 1 started receiving blood transfusions via the Central line.

At 5:41 p.m., Patient A had a second CT scan with contrast.

At 6:06 p.m., the Nurse's Notes indicated Patient 1 became unresponsive during the second CT scan and, "Code Blue called when pt (Patient 1) became unresponsive in CT... pale, cool, mottled skin, hypotensive, and increased heart rate, (ED MD) has spoke [sic]with (GEN SURG 1) 8x (eight times) regarding this pt."

At 6:26 p.m., the second CT result was called to the ED MD by the radiologist. The CT result indicated,"...Increased hemoperitoneum. Pelvic collection now measures 8.7 x 14.3, previously 3.7 x 11 cm (centimeters). Blood in the

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paracolic gutters (spaces between the colon and abdominal wall). Increased perihepatic and perisplenic fluid (fluid around the liver and spleen). Irregular laceration of the spleen which extends to the splenic hilum (area of spleen where the splenic artery and vein enter the spleen)...concerning for active extravasation (active bleeding)."

At 6:27 p.m., the ED Physician's Notes indicated the ED MD called GEN SURG 1 again and GEN SURG 1 was unavailable to see Patient 1, "...still in the OR, Will call (radiologist) about the CT reading."

At 6:31 p.m., the Nurse's Notes indicated, "Clarify awaiting (GEN SURG 1)...to evaluate patient for surgery."
Between 7:01 p.m. and 7:14 p.m., the ED physician's notes indicated ED MD called four additional general surgeons none of whom were on call that day. ED MD requested a surgical consult, but all four surgeons stated that they were unable to see Patient 1 in the ED.

At 7:05 p.m., Patient 1 was intubated (tube inserted through the mouth into the airway to keep the airway open), and placed on a ventilator (artificial breathing machine), for respiratory distress.

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At 7:20 p.m., the ED Physician's Notes indicated the ED MD spoke to GEN SURG 1 by phone and GEN SURG 1 was, "on his way to the ED to perform surgery on the pt (Patient 1). Will be here in 25 minutes."

At 7:51 p.m., the ED Physician's Notes indicated GEN SURG 1 arrived in the ED at the Facility A (four hours and 54 minutes after the initial telephone consult).

The record indicated Patient 1 was ordered to receive two units of fresh frozen plasma (blood product used during blood transfusions to replace clotting factors) and two units of platelets (blood products given to ensure blood clotting and reduce bleeding) when GEN SURG 1 arrived.

At 8:17 p.m., the ED Physician's Notes indicated GEN SURG 1 recommended Patient 1 be transferred to Facility B to be treated by a Trauma Surgeon. The Notes indicated the Trauma Surgeon at Facility B accepted Patient 1 to be transferred by air transport (five hours and 20 minutes after the initial surgical consult was requested by the ED MD at Facility A).

At 8:50 p.m., the Physician's Notes indicated, "(name of a second doctor) will accept the pt via (air transport)."

At 10:15 p.m., Patient A was transferred out of the Facility A with diagnoses that included

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splenic laceration, hemoperitoneum, hypotension, and respiratory failure.

The Nurse's Notes indicated, "transferred to (Facility B) for trauma surgery consult...remains in critical condition, intubated, with intravenous fluids (IV) infusing, levophed (medication given to maintain blood pressure) started by (air transport) prior to depart and pt receiving plasma (blood transfusion) during transfer." (a total time of seven hours and 18 minutes after the ED MD requested the initial consult for further evaluation and stabilizing treatment of Patient 1's condition).

On October 20, 2017, at 9:30 a.m., a review of Patient 1's record from Facility B was conducted. The record indicated Patient 1 arrived at Facility B via air transport from Facility A on September 7, 2017, at 10:42 p.m. The record indicated Patient 1 had a diagnosis of splenic laceration, was intubated and unresponsive, and had a distended abdomen. The record indicated Patient 1's blood pressure was 81/64 mmHg and heart rate was 111 beats per minute on arrival to Facility B.

The record further indicated Patient 1 had a CT scan at Facility B that indicated a Grade 5 splenic injury (splenic injuries graded 1-5 with Grade 5 most severe and defined as a loss of blood supply to spleen due to destruction of blood vessels or a shattered spleen) with extensive hemoperitoneum.

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The record indicated Patient 1 received five units of blood, five units of plasma, and multiple medications to maintain his blood pressure in Facility B's ED.

The History and Physical, dated September 8, 2017, at 12:30 a.m., indicated Patient 1 "has undergone massive transfusion protocol, but his blood pressure is declining despite being on blood pressure medications."

The Critical Care Notes, dated September 8, 2017, at 7:26 p.m., indicated Patient 1 was deemed unsafe for surgery, was minimally responsive, had low blood pressure, and severe acidosis (abnormal blood chemistry).

The Death Summary indicated Patient 1 passed away on September 9, 2017, at 3:51 p.m.

An interview was conducted with the ED Clinical Manager (EDCM) and the Chief Nursing Officer (CNO) on October 4, 2017, at 10:40 a.m., regarding the facility's process for obtaining specialty physician consults in the ED. The EDCM stated the ED physician would evaluate the patient in the ED and order a specialty physician consult. The EDCM stated the ED secretary or physician would then call the specialty physician on-call that day. The EDCM stated the usual response time from the specialty physician was 15 minutes. The EDCM stated if no response was received, a second call was made to the specialty physician. If no response was received after the second call,

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the ED staff would call the chief of the specialty department, and expect them to either see the patient, or call the on-call physician to see the patient in the ED.

On December 6, 2017, at 1:53 p.m., the ED MD was interviewed. The ED MD stated he was on duty in Facility A's ED on September 7, 2017, and remembered Patient 1. The ED MD stated he called the General Surgeon on-Call (GEN SURG 1) multiple times and requested GEN SURG 1 come to Facility A for consult and to further treat and stabilize Patient 1 in the ED. The ED MD stated he made it "patently clear" that he wanted GEN SURG 1 to come to the ED and evaluate Patient 1. The ED MD stated Patient 1 had "clearly documented peritoneal signs" that indicated Patient 1's condition was worsening. The ED MD stated he had "never had a delay of that length." in the ED at Facility A. The ED MD stated he was not aware of any "back-up" coverage in place for the on-call surgeons at Facility A. The ED MD stated, "there was no one to help me." when he requested help for Patient 1.

On December 6, 2017, Surveyor A requested an interview with GEN SURG 1. On December 7, 2017, at 8:25 a.m., the Director of Quality Management (DQM) indicated GEN SURG 1 declined to be interviewed.

The facility Medical Staff Roster for General Surgeons was reviewed on October 5, 2017,

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and indicated there were eight General Surgeons with active privileges at the facility during the month of September 2017.

The Emergency Room Physicians On-Call (ER Call) schedule for September 2017 was reviewed on October 5, 2017. The ER Call schedule indicated General Surgeons were placed on-call for the ED for one week at a time, 24 hours a day. The ER Call schedule indicated GEN SURG 1 was on-call for the ED on September 7, 2017.

There was no documentation that indicated GEN SURG 1 had made arrangements for another surgeon to respond to Facility A's ED while he was in the Operating Room at Facility B.

On December 7, 2017, the credential file for GEN SURG 1 was reviewed. The file document titled, "Credentials Committee Interview Checklist," dated November 29, 2014, indicated GEN SURG 1 acknowledged and signed that he was required to respond timely to Facility A's ED for consults "within 30 minutes."

The Death Certificate issued May 21, 2018, indicated the cause of death (for Patient 1) as "Complications of Blunt Force Splenic Trauma." "Anticoagulation Therapy" was listed as another significant condition contributing to the patient's death.

The facility policy and procedure, titled,

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"EMTALA, "dated January 22, 2014, was reviewed. The policy indicated, "A determination as to whether an on-call physician must physically assess the individual in the emergency department is the decision of the treating emergency physician."

Facility's A's Medical Staff Rules and Regulations, dated February 20, 2014, were reviewed. The Rules and Regulations indicated, "Members of the Medical Staff shall be expected to provide consultation services in their respective specialty upon request from a fellow physician...Physicians are expected to respond to consult requests in a timely manner...In all cases where diagnosis is obscure or when there is doubt...consultation shall be sought...The Emergency Service shall select the appropriate on-call panel member or members necessary for the emergent care of the patient and to cause such member or members to attend to the patient...A Panel member shall respond in a prompt and timely manner, not exceeding thirty (30) minutes unless waived by the Director of Emergency Medicine or his/her designee...Any physician on-call for the Emergency Room must remain within the [facility region], or make coverage arrangements by an appropriate physician of the [facility name] Medical Staff, so as to permit prompt response to the E. R."
Facility A failed to ensure the on-call physician was available to respond timely to evaluate, further treat, and stabilize Patient 1 in the ED when requested by the ED physician. This

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| | failure resulted in the delay in medical treatment for Patient 1, which contributed to the decline in Patient 1's medical condition, and ultimately required Patient 1 to be transported to Facility B in critical condition; and contributed to Patient 1's death 50 hours and 34 minutes after being transported to Facility B.<br>These failures are deficiencies that have caused, or are likely to cause serious injury and/or death to the patient, and therefore constitute an immediate jeopardy within the meaning of Health and Safety Code, Section 1280.3.<br><br>This facility failed to prevent the deficiency(ies) as described above that caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.3(g). | | | |