

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2009
NAME OF PROVIDER OR SUPPLIER HOAG MEMORIAL HOSPITAL PRESBYTERIAN		STREET ADDRESS, CITY, STATE, ZIP CODE ONE HOAG DRIVE, NEWPORT BEACH, CA 92663 ORANGE COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit.</p> <p>The following reflects the findings of the Department of Public Health during investigation of COMPLAINT # CA00173787</p> <p>The inspection was limited to the complaint(s) investigated and does not represent a full inspection of the hospital.</p> <p>Representing the Department of Public Health: [REDACTED], HFEN; [REDACTED], MD</p> <p>DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY</p> <p>70213(d) Nursing Service Policies and Procedures (d) Policies and procedures that require consistency and continuity in patient care, incorporating the nursing process and the medical treatment plan, shall be developed and implemented in cooperation with the medical staff.</p> <p>70701(a)(4) Governing Body (a) The governing body shall: (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.</p> <p>The above regulations were NOT MET as evidence by:</p> <p>Based on interview and record review, the hospital</p>			

Event ID:V22111

9/2/2009

3:48:42PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2009
NAME OF PROVIDER OR SUPPLIER HOAG MEMORIAL HOSPITAL PRESBYTERIAN		STREET ADDRESS, CITY, STATE, ZIP CODE ONE HOAG DRIVE, NEWPORT BEACH, CA 92663 ORANGE COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	<p>Continued From page 1</p> <p>failed to ensure that the attending physician's order for continuous cardiac monitoring was implemented as ordered, resulting in Patient A being at risk for undetected cardiac arrhythmias. Subsequently, Patient A was found to have suffered ventricular fibrillation, coded and expired.</p> <p>In addition the governing body failed to provide adequate physical resources to ensure that the monitor technician was sufficiently free of other duties to ensure Patient A, who was off the cardiac monitor for greater than 30 minutes, was observed and treated.</p> <p>Findings: On 2/4/09, Patient A's medical record was reviewed. The record showed on 12/28/08 Patient A came to the hospital ED (Emergency Department) complaining of chest pain. A review of the History and Physical report of 12/28/08 revealed the ED physician documented that Patient A had a history of Coronary Artery Disease with insertion of an intra-coronary stent. Patient A's ER electrocardiogram showed evidence of abnormal changes and the patient was diagnosed with an acute myocardial infarction. Patient A was taken directly to the cardiac catheterization laboratory for a left heart catheterization, a coronary angiography, and stent insertion.</p> <p>The Physician's Progress Notes of 12/29/08 showed the patient was monitored in the Coronary Care Unit, having episodes of ventricular tachycardia, attributed to re-perfusion, a common occurrence, following stent insertion. The patient</p>			

Event ID:V22111

9/2/2009

3:48:42PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/04/2009
NAME OF PROVIDER OR SUPPLIER HOAG MEMORIAL HOSPITAL PRESBYTERIAN			STREET ADDRESS, CITY, STATE, ZIP CODE ONE HOAG DRIVE, NEWPORT BEACH, CA 92663 ORANGE COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
	<p>Continued From page 2</p> <p>did not complain of chest pain. The physician ordered transfer to the telemetry floor for continuing care and cardiac monitoring.</p> <p>At 0607 hours on 12/30/08, the nursing notes on the telemetry unit revealed that the night shift nurse assessed Patient A as being "alert and orientated", "denied any discomfort nor chest pain." "No changes in the previous assessment unless otherwise noted."</p> <p>At 0710 hours, the Primary Care Assistant (PCA) found Patient A in the bed. The patient appeared breathing, was diaphoretic (sweating profusely), but showed no verbal response when the PCA tried to take AM vital signs. A Code Blue (resuscitation) was initiated.</p> <p>At 0715 hours on 12/30/08, the Emergency Physician Record for the Code Blue revealed that the PCA initiated Patient A's Code Blue. Patient A was observed to be disconnected from the cardiac monitor. When placed back on the monitoring device, the patient was found to be in ventricular fibrillation. The Code Blue team delivered electrical defibrillation multiple times. The physician pronounced the patient dead at 0730 hours.</p> <p>The Discharge Summary dated 12/31/08, showed Patient A expired on 12/30/08. Patient A was doing well and was moved to the telemetry unit on the day following insertion of the coronary artery stent. On that same day, Patient A was "apparently off the monitor for 35 minutes and during that time suffered an arrhythmic death."</p>				

Event ID:V22111

9/2/2009

3:48:42PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/04/2009
NAME OF PROVIDER OR SUPPLIER HOAG MEMORIAL HOSPITAL PRESBYTERIAN			STREET ADDRESS, CITY, STATE, ZIP CODE ONE HOAG DRIVE, NEWPORT BEACH, CA 92663 ORANGE COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
	<p>Continued From page 3</p> <p>The printed strips of the cardiac monitor for Patient A showed on 12/30/08 at 0641 hours, the monitor did not register the patient's cardiac activity, and the strip went abruptly into a flat line. The medical record for 12/30/08 revealed no monitoring from 0641 hours to 0715 hours a duration of 34 minutes.</p> <p>On 2/4/09 at 1045 hours, interview with the Director of the telemetry unit was conducted. The Director stated the telemetry technician (TT) and clerical coordinator (CC) on 12/3/08 was the same person. The day shift started at 0700 hours. Before the new shift started at approximately 0630 hours, was the busiest time of the shift. The CC had many tasks to do including answering the telephone, answering patients' call-lights then paging the nurses for response, updating and writing the unit census, picking up laboratory reports and placing them on clipboards. These duties were in addition to the telemetry duties of watching the cardiac monitors and notifying the nurses of abnormalities. The TT assigned to watch the monitor on 12/30/08 was on his second night of working in the unit. The TT did not notify the patient's nurse or PCA when Patient A's cardiac monitor was not registering a rhythm. The alarm for the cardiac monitoring system was not set on the highest volume.</p> <p>On 2/4/09 at 1100 hours during an interview, the PCA stated on the morning of 12/30/08, she walked into Patient A's room to check the vital signs. She found Patient A was not responding and the telemetry leads were off. She went to get a new pack of leads and came back to the patient's room.</p>				

Event ID:V22111

9/2/2009

3:48:42PM

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/04/2009
NAME OF PROVIDER OR SUPPLIER HOAG MEMORIAL HOSPITAL PRESBYTERIAN			STREET ADDRESS, CITY, STATE, ZIP CODE ONE HOAG DRIVE, NEWPORT BEACH, CA 92663 ORANGE COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
	<p>Continued From page 4</p> <p>She called the Code Blue team.</p> <p>Review of hospital records showed a statement from the TT/CC that 12/29/08 night shift was the second night for the TT/CC on the telemetry unit. The TT/CC described that night as busy; there were many telemetry alarms going off. The assigned workload was 20% cardiac monitoring and 80% clerical work. The TT did not notify the nurse of when Patient A's cardiac rhythm was not registering and/or the monitor was alarming.</p> <p>The Telemetry Technician/Clerical Coordinator Job Description revealed the TT/CC should maintain constant monitoring of electrocardiogram patients throughout the entire shift, recognize changes in electrocardiograms and inform the registered nurse of changes. In addition to the above, the TT/CC worked as part of the patient care delivery team to maintain organization within the unit including:</p> <ul style="list-style-type: none"> * Coordinating patient schedules with other members of the patient care delivery team * Managing patient charts and prioritizing; and transcribing orders in an accurate, timely and efficient manner * Perform other duties as assigned. <p>The violation(s) has caused or is likely to cause serious injury or death to the patient(s).</p>				

Event ID:V22111

9/2/2009

3:48:42PM

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.