CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050102	A. BUILDING _____ B. WING _____	04/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW COMMUNITY HOSPITAL MEDICAL CENTER	3865 Jackson St, Riverside, CA 92503-3919 RIVERSIDE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00513631 - Substantiated Representing the Department of Public Health: Surveyor ID # 2369, 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 1280.3(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. Abbreviations used in this document: ACLS - Advanced Cardiovascular Life Support cm - centimeters CT - computed tomography DOU - Definitive Observation Unit DRS - Director Radiology Services ICU - Intensive Care Unit IV - intravenous MD - Physician NP - Nurse Practitioner TKO - to keep open Health and Safety Code section 1280. (3)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

By signing this document, I am acknowledging receipt of the entire citation packet, *Page(s). 1 thru 12*

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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	(a) Commencing on the effective date of the regulations adopted pursuant to this section, the director may assess an administrative penalty against a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 for 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. (b) Except as provided in subdivision (c), for a violation of this chapter or the rules and regulations promulgated thereunder that does not constitute a violation of subdivision (a), the department may assess an administrative penalty in an amount of up to twenty-five thousand dollars ($25,000) per violation. This subdivision shall also apply to violation of regulations set forth in Article 3 (commencing			

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	with Section 127400) of Chapter 2 of Part 2 of Division 107 or the rules and regulations promulgated thereunder. Title 22 of the California Code of Regulations Section 70203(a)(2) Medical Service General Requirements (a) A committee of the medical staff shall be assigned responsibility for: (2) Developing, maintaining and implementing written policies and procedures 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. Findings: Based on interview and record review, the Medical Staff did not follow or implement facility policies and procedures by failing: a. To confirm placement of a central line placement, after the line was adjusted by the physician; and b. To act on the x-ray result that confirmed the line required repositioning and further evaluation. These failures resulted in the extravasation (leaking) of intravenous fluid in Patient 2's			

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	pleural cavity (the fluid-filled space that surrounds the lungs). {Extravasation is a [serious, infusion-related complication in which the drug being infused into the body through an IV (intravenous) escapes the vein and intrudes into the surrounding tissue] of these medications into the tissues may cause necrosis and sloughing of surrounding tissue. [Ref. Lexicomp-{https://online.lexi.com- an online clinical reference for healthcare professionals, October 2017.]} Subsequently, the patient underwent a thoracentesis procedure (a procedure to remove fluid), intubation (the insertion of a tube into the airway to assist with breathing), and intensive care monitoring, all of which contributed to Patient 2's death. On December 9, 2016, the record for Patient 2 was reviewed. Patient 2 was admitted to the facility through the Emergency Department, on December 4, 2016, with diagnoses including altered mental status, diabetes, and respiratory failure. The "Emergency Department Record - Physician Chart" dated December 4, 2016, at 6:27 p.m., indicated a right central line (catheter placed in a large vein) was placed by Physician 1 via an intraclavicular (chest area below the clavicle) approach. A chest x-ray was ordered on December 4, 2016, at 6:28 p.m., and completed at 6:52 p.m.,			

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	to determine if the central line was in the correct position with the following results: "Right central line going into the right jugular vein. This should be repositioned." The "Emergency Department Record - Physician Chart" dated December 4, 2016, at 6:57 p.m., indicated "advised that right central line is in jugular vein. Will retract (pull back) 3 cm (centimeters)." There was no documentation that indicated the right central line was repositioned. During an interview with Physician 1, on December 20, 2016, at 1:35 p.m., he stated an initial x-ray for central line placement was obtained, and he did retract the central line 2 to 3 centimeters but did not document the procedure in the record. Physician 1 stated he did not order a chest x-ray to verify placement after he had retracted the line, and a repeat chest x-ray should have been done. During an interview with Radiologist 1 and the Director Radiology Services (DRS), on December 9, 2016, at 12:10 p.m., Radiologist 1 stated the standard practice is to obtain a chest x-ray, after the placement of a central line, to verify if the placement/location of the central line is correct. Radiologist 1 stated if the central line was not in the correct location the nurse or physician would be called, and this telephone call would be documented in the patient's record. Radiologist 1 stated the correct			

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placement of a central line should be verified prior to the line being used to administer medications (in order to prevent extravasation of fluid).

The facility policy and procedure titled "Central Venous Line, Assisting With Insertion" revised April 2007, and reviewed July 2011, indicates, "... When catheter is in place, infuse IV solution at To Keep Open (TKO) rate. Infuse IV at ordered rate after chest x-ray has verified placement if subclavian line is placed. "

Record review indicated Patient 2 was admitted to the Direct Observation Unit (DOU) on December 4, 2016, at 8 p.m.

On December 5, 2016, at 7:44 a.m., a chest x-ray was ordered for the clinical indication of "respiratory failure." The radiologist (Supervising Physician Radiology (SPR) impression (reading) indicated the following results:
"New complete whiteout of the right lung; and
"New irregular central line with an unusual course overlapping the right hemi thorax" (one side of the chest) and a "CT scan of the chest is strongly recommended for more complete assessment."

Computed tomography scan (CT) uses X-rays to make detailed pictures of parts of the body and the structures inside the body.

There was no documentation that indicated the

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	Radiologist notified the physician of the results regarding the location of the right central line or the recommendation for a more complete assessment. The facility policy and procedure titled, "Critical Values" revised June 2014, indicates "... It is the responsibility of a radiologist to expedite communication of radiologic critical values, which are findings that necessitate emergent intervention... A radiologist will immediately communicate with the ordering physician whenever possible... The date, time of communication and ordering physician will be documented as an addendum to the final report." During an interview with SPR, on March 23, 2017, at 8:35 a.m., he stated, "A misplaced line (not in the correct location) is a 'critical value' and the ordering physician should have been notified." The SPR stated the Radiologist should document when a physician was notified of a "critical value" x-ray result. The SPR stated it was "necessary and appropriate" to contact the physician and document such for any "critical value." The record indicated a right sided thoracentesis was performed by an Interventional Radiologist on December 5, 2016, at 11:30 a.m., and 1,570 milliliters of fluid was removed. Physician 2's progress note dated December 5, 2016, at 3:38 p.m., indicated there was a			

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	"complete white out" (indicates pneumonia or heart failure) of the right lung and a thoracentesis was performed. There was no documentation to indicate Physician 2 acted upon the radiologist's recommendation on December 5, 2016, at 7:44 a.m., which indicated a more complete assessment of the central line placement was needed. During an interview with the Chief of Staff (COS), on March 23, 2017, at 8:43 a.m., he stated, the ordering physician should have reviewed all results of tests ordered. The COS stated the physician was ultimately responsible to review results of tests ordered. In addition, the COS stated a central line not in the correct location was a "critical value." The record indicated Patient 2 was transferred to the Intensive Care Unit (ICU), on December 5, 2016, at 4:45 p.m. The "Pulmonary Critical Care Progress Note" by Physician 3, dated December 5, 2016, at 9:36 p.m., indicated Physician 3 had discussed the case with Nurse Practitioner (NP) 1, and "MD reviewed all imaging and labs and agrees with the plan." There was no documentation that indicated Physician 3 addressed the chest x-ray results dated December 5, 2016, at 7:44 a.m., which indicated the right central line was not in the			

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	correct location. On December 6, 2016, at 8:40 a.m., a chest x-ray was ordered for the clinical indication of "shortness of breath, respiratory failure." The Radiologist (Radiologist 2) impression (reading) indicated: "Stable complete opacification (areas of fluid collection) of the right hemithorax (the accumulation of blood between the linings of the lung), likely corresponding to complete... (Lung collapse and fluid collection) of the right lung combined with... (A buildup of fluid between the lung and chest cavity). The course of the right-sided central line remains irregular and the central line may not be located within the vasculature. Further characterization with CT continues to be recommended." There was no documentation that indicated Radiologist 2 notified the Physician of the results regarding the location of the right central line. The "Intensive Care Record" dated December 6, 2016, at 2:20 p.m., Indicated Patient 2 required intubation (the placement of a tube into the airway) to assist with breathing. On December 6, 2016, at 2:46 p.m., a CT of the chest was ordered for the clinical indication of "shortness of breath, history of recent central line placement" (44 hours after the right central			

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	line was placed and 31 hours and 16 minutes after the first recommendation by the radiologist for a CT scan). The CT results indicated "Right-sided central line is not within the vessel. Large loculated (divided into small spaces) right pleural effusion with associated compressive atelectasis (collapse of the lung) and only a small amount of residual aerated (containing air) right lung." The record indicated the medications that had been administered through the right central line included: - Sodium bicarbonate in saline solution (used to a condition in which there is too much acid in the body); dispensed in 500 cc's (cc-cubic centimeter- a unit of measurement) IV solution. - Albumin (plasma protein important in regulating the exchange of water between the plasma and the interstitial compartment [space between the cells]); - Lasix (used to treat fluid buildup due to heart failure); - Antibiotics; - Dopamine (used to increase the contractility of the heart and increase heart rate) dispensed in 250 cc IV solution; - Neo-synephrine (used to increase blood pressure); and - Levophed iv solution (increases heart rate and blood pressure, triggers the release of glucose from energy stores, increases blood flow to skeletal muscle, reduces blood flow to			

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	the gastrointestinal system, and inhibits voiding of the bladder). The record indicated the right subclavian central line was removed on December 6, 2016, at 6:12 p.m. (47 hours and 45 minutes after the line had been placed). The record indicated on December 6, 2016, at 7:34 p.m., a right sided chest tube was placed at the base of Patient A's right lung, which resulted in the removal of a "large" amount of clear amber colored fluid. Radiologist 1 reviewed the record for Patient 2, and was unable to find documentation that the Radiologist notified a nurse or physician when the right central line was noted, on chest x-rays, to be "irregular" and possibly not in the vein, on December 4, 2016, at 6:52 p.m.; December 5, 2016, at 7:44 a.m.; and December 6, 2016, at 8:40 a.m. Radiologist 1 stated the physician should have been notified, when on chest x-ray, the location of the right central line did not look correct. In addition, Radiologist 1 stated if a central line was repositioned, a repeat chest x-ray should be done to confirm placement after the adjustment. The physician document titled "Death Summary Report" dated December 24, 2016, at 12:10 p.m., indicated Patient 2 died on December 24, 2016, at 11:37 a.m. with final diagnoses to			

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	include acute respiratory failure. The facility "Bylaws of the Medical Staff" revised June 29, 2016, indicates, "... The general functions of each department shall include: ... reviewing and evaluating departmental adherence to: 1) medical staff policies and procedures and 2) sound principles of clinical practice;" The Medical Staff did not follow their own facility Medical Staff Bylaws by failing to obtain a post procedure chest x-ray to confirm the central line's placement, failing to communicate the radiology diagnostics, and failing to act upon the radiologist's recommendations to follow up on the line's placement. 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).			

Parkview
Community Hospital
Medical Center

March 22, 2018

California Department of Public Health
Licensing and Certification Program
Riverside District Office
ATTN: Theresa Hawkinson, HFE Supervisor
625 East Carnegie Drive, Suite 280
San Bernardino, CA 92408

RE: **CA00513631 - Plan of Correction**
Facility ID: 250000044
Penalty Number: 250013809

The following plan of correction is submitted for your review and approval:

T22 DIV5 CH1 ART3-70703(a)(2) Medical Service General Requirements

1. The adverse event was reported to the Governing Board. **(February 22, 2017)**
2. The Director of Medical Staff Services sent a memorandum to all Medical Staff Directors and the ER Department Physicians a copy of the facility policy and procedure, "Critical Values" revised June 2014 titled, for education and informational purposes. **(April 28, 2017)**
3. A memorandum from the Chief of Staff and Chief Quality Officer was sent to the Medical Staff addressing the following **(March 19, 2018)**:
    a. Central Line Insertions
        i. All central line insertions shall be confirmed for correct positioning via X-ray prior to line use.
        ii. If an adjustment is indicated as a result of the initial X-ray, then a subsequent X-ray shall be conducted to confirm correct positioning prior to line use.
        iii. The physician and/or staff inserting the central line shall document that the correct placement was confirmed and the line is ready for use.
    b. Laboratory, Diagnostic, and Therapeutic procedures
        i. The ordering and/or covering physician shall document in the medical record that the results of the aforementioned procedures were reviewed and interventions ordered, if needed.
4. An email from the Medical Director of Radiology to all Radiologists re the notification of critical test results with the following **(December 8, 2016)**:
    a. It is IMPERATIVE that all important and/or critical findings are called to the referring physician.
    b. You must document your calls as well to the referring physician and/or nurse.
5. A random review of central lines placed is conducted to ensure the following **(January 2017)**:
    a. Correct placement is confirmed via X-ray.

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b. Malpositioned central lines identified via X-ray are adjusted and a second X-ray is conducted to confirm correct placement.
c. A finding of non-compliance is reported to the Peer Review Committee and the Governing Board.

6. A Quality Control (QC) review of Critical Test Results was initiated to ensure compliance with the hospital policy and procedure, "Critical Values" revised June 2014. The QC findings are reported to Quality Council quarterly and forwarded to the Medical Executive Committee and Governing Board for review and discussion, if needed. **(January 2017)**
7. A Clinical Contract Review was completed for:
    a. Emergency Services on **May 31, 2017**
    b. Radiology Services on **March 8, 2017**
8. Peer Review Committee:
    a. MD #1 completed **March 2, 2017**
    b. MD#2 completed **May 4, 2017**
    c. Radiologist completed **April 6, 2017**

Thomas J. Santos, R.N.
Chief Quality Officer