<table>
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<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDERS PLAN OF CORRECTION</th>
<th>COMPLETE DATE</th>
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|        | The following reflects the findings of the California Department of Public Health during an Entity Reported Incident/Adverse Event visit. | Corrective Actions:  
1. Development of Hospital Wide Policy "Insertion & Assessment of Central Intravascular Catheters" and Central Line Insertion Note (Attachment A) | 8/31/09 |
|        | Entity Reported Incident/Adverse Event: CA00163278 - Substantiated | 2. To ensure patient safety immediately after initial insertion (ALL). | 8/31/09 |
|        | The inspection was limited to the specific entity reported incident/adverse event investigated and does not represent the findings of a full inspection of the facility. | a. Assess patient condition; auscultate breath sounds, mentation, and vital signs. |
|        | 70203(a) (2) Medical Services 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. | c. Initial Chest X-ray is ordered/performed to assure catheter placement location, removal of guide wire, or potential complication (i.e. pneumothorax), prior to infusion of IV fluids. |
|        | Based on staff interview, physician interview, medical record review, and document review, the facility failed to ensure that the medical staff developed and implemented the central venous catheter (CVC) policy for pre and post central venous catheter insertion, incorporating the CVC manufacturer's safety guidelines. The medical staff | d. Proceduralist completes Central Line Placement Note or if PICC line placement, PICC Insertion/Repair record, proceduralist or nursing staff document confirmation of X-ray catheter placement in medical record. |
CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CIA
IDENTIFICATION NUMBER.

061318

(X2) MULTIPLE CONSTRUCTION
A BUILDING
B. WING

(X3) DATE SURVEY
COMPLETED

11/07/2008

NAME OF PROVIDER OR SUPPLIER
REDWOOD MEMORIAL HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE
5500 RENNER DRIVE, FORTUNA, CA 95540 HUMBOLDT COUNTY

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<td>(25) COMPLETE DATE</td>
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<td>9/30/09</td>
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Failed to ensure the procedure included steps to take to ensure that the CVC is in the correct position and the guide wire, which is used during the catheter insertion procedure, is removed after the catheter insertion in order to prevent complications from occurring. A guide wire was left in Patient 1 following the insertion of the CVC. This resulted in the guide wire migrating up to Patient 1's neck and required the emergent transfer of Patient 1 to another acute care hospital's cath lab for a second procedure to immediately remove the guide wire. These failures placed Patient 1 at potential risk for complications, Intentional injuries, and/or death from the migrated guide wire.

THE VIOLATION OF LICENSING REQUIREMENTS CONSTITUTED AN IMMEDIATE JEOPARDY (IJ) WITHIN THE MEANING OF HEALTH AND SAFETY CODE SECTION 1280.11 IN THAT IT CAUSED, OR WAS LIKELY TO CAUSE SERIOUS INJURY OR DEATH TO THE PATIENT. WHEN MEDICAL AND NURSING STAFF FAILED TO IDENTIFY THAT THE CENTRAL VENOUS CATHETER GUIDE WIRE HAD NOT BEEN REMOVED FROM THE PATIENT AFTER THE CVC INSERTION PROCEDURE. THIS VIOLATION PLACED THE PATIENT AT INCREASED RISK FOR COMPLICATIONS AND DEATH FROM THE RETAINED GUIDE WIRE.

Findings:

Patient 1 was admitted to the Emergency Department (ED) on 9/8/08 at 1:30 p.m., with diagnoses including grand mal seizure, acute

Event ID: SD0311 813/2008 3:19:45PM
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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 patient. 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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Total P.002
Continued From page 2

gastrointestinal (GI) bleed, hypovolemic (low blood volume), nasal fracture, and complaints of neck pain. Patient 1 had a temperature of 99.6°Fahrenheit (F), pulse 106, respirations 20, and blood pressure of 75/21 (normal range 120/80).

The physician’s ED record dated 9/8/08, indicated that at 2:08 p.m., an intravenous (IV) was started and 1000 cc of normal saline was given. Patient 1 had no change in his pulse rate. Another 1000 cc of normal saline was given at 2:30 p.m.; with no change in Patient 1’s blood pressure or pulse. An interosseous (IO-infusing IV fluids in the bone marrow cavity) was inserted in the left tibia and 500 cc of normal saline was infused, and Patient 1’s leg began to swell. A left femoral vein central venous catheter was then inserted using ultrasound guidance.

During an interview on 9/23/08 at 8:00 a.m., Physician A stated that it was a very busy shift. Patient 1 had cervical spine precautions and his neck had not been cleared, so he avoided inserting a central venous catheter in the jugular or subclavian area (neck area). Physician A said Patient 1 had a GI bleed and was hypovolemic. Physician A inserted the central venous catheter in the left femoral vein, threaded the triple lumen catheter over the spring-wire guide wire, but did not take the caps off the triple lumen ports, leaving the guide wire in Patient 1. Physician A said, “I spaced out and it was a regrettable incident.”

During an interview on 9/19/08 at 10:10 a.m., Licensed Nurse B stated that on 9/8/08, she was
Continued from page 3

helping out in the ED and had assisted Physician A with the central venous catheter insertion. Licensed Nurse B stated that they started infusing IV solutions and blood products. Licensed Nurse B said they had cleaned up all the equipment and supplies after the central venous catheter insertion and did not think about or look for the guidewire.

Physician A stated that on 9/8/08, the next evening he was thinking back on the events of the previous day, when he could not remember if he had taken the guidewire out of Patient 1. Physician A called the ED physician on duty and asked to have an x-ray taken of Patient 1's femoral area.

The x-ray report dated 9/9/08 indicated, "There is a wire-like device noted overlying the inferior portion of the inferior vena cava. This apparently is a wire that was placed or lost during placement of the iliac catheter."

During an interview on 9/23/08 at 9:06 a.m., Physician A said in the morning on 9/10/08, he went to look at Patient 1's x-ray. Then, Physician A went to look at the position of the electrocardiogram (EKG) wires and confirmed with nursing staff that the EKG wires had not been over the femoral area. An abdominal x-ray on 9/10/08 revealed that the guidewire had migrated to Patient 1's neck.

The manufacturer's instructions and recommendations for the use of the multiple lumen central venous catheter, dated 3/02, indicated the following:


"Warnings and Precautions (all written in red): 2. Warning: Do not place the catheter into or allow it to remain in the right atrium or right ventricle (heart chamber). For femoral vein approach, the catheter should be advanced into the vessel so that the catheter tip lies parallel to the vessel and does not enter the right atrium. 6. Warning: Passage of the guide wire into the right heart can cause dysrhythmias (irregular heart beat), right bundle branch block, and a perforation of the vessel wall, atrial or ventricular. 13. Precaution: Only x-ray examination of the catheter placement can ensure that the catheter tip has not entered the heart or no longer lies parallel to the vessel wall. If the catheter position has changed, immediately perform chest x-ray examination to confirm catheter tip position."

Continued From page 5

product has been designed to freely pass over the spring-wire guide... 14 Verify that the entire spring-wire guide is intact upon removal. 17. Verify catheter tip position by chest x-ray immediately after placement... If catheter tip is malpositioned, re-position and re-verify... 18. Secure catheter to patient using staple anchoring device, sutures, or "Statlock" anchoring device... Dress insertion site according to hospital protocol.

The ED record & nurses notes dated 9/8/08 and the dictated ED physician's record dated for 9/8/08 electronically signed on 9/10/08, did not document the positioning of the patient for the procedure, did not include that an x-ray was immediately taken after the procedure to determine correct catheter placement and/or the presence of the guide wire, did not include the length of the central venous catheter from the insertion site using the catheter's centimeter marks as a point of reference, and did not include that the entire spring-wire guide wire was verified and inspected upon removal.  

The facility's central venous catheter policy and procedure revised on 5/2006, was stated as a hospital wide nursing policy and addressed care provided by registered nurses for the various types of central catheters after insertion and during use for intravenous therapy. The policy did not reflect any of the warnings, precautions, and/or guidelines as indicated by the manufacturer for the triple lumen central venous catheter for the insertion of the catheter, verification and inspection of the guide wire, and determining correct catheter placement by immediate x-ray in order to prevent...
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The facility's failure to develop and implement the central venous catheter policies and procedures to ensure patient safety is a deficiency that has 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 1280.1.

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Event ID: SDO311  3/13/2009  3:12:45PM

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE  (X9) DATE

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