### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 050054  
**(X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:**  
**(X3) DATE SURVEY COMPLETED:** 05/30/2008

#### NAME OF PROVIDER OR SUPPLIER
SAN GORGONIO MEMORIAL HOSPITAL

#### STREET ADDRESS, CITY, STATE, ZIP CODE
600 NORTH HIGHLAND SPRINGS AVENUE, BANNING, CA 92220-3090  RIVERSIDE COUNTY

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARIZED STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following reflects the findings of the California Department of Public Health during a Complaint investigation (#CA00138472).

Representing the Department:

On January 24, 2008, at 9:55 a.m., Immediate Jeopardy (IJ) was identified regarding the facility’s Pharmaceutical Services and Basic Emergency Medical Services. The IJ was abated on January 24, 2008, at 1:30 p.m.

The IJ resulted in the potential for serious harm and death in all pediatric patients due to the facility’s failure to ensure the availability of a complete and effective system for emergency care and resuscitation of pediatric patients (children 12 years and under).

**A 012 1280.1 (a)**

If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars ($25,000) per violation.

**A 014 1280.1 (c)**

---

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.
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.

T22  DIV5  CH1  ART3-70263 (f). Pharmaceutical Service General Requirements

(f) Supplies of drugs for use in medical emergencies only shall be immediately available at each nursing unit or service area as required. Based on observation, interview, and record review, the facility failed to ensure availability of the correct drugs for treatment of pediatric emergencies in the Emergency Department (ED), Post Anesthesia Care Unit (PACU), medical surgical, and radiology areas, resulting in the potential for administration of incorrect and ineffective drug doses and death during resuscitation of a pediatric patient.

Findings:

The facility's policy titled, "Code Cart: Pediatric," was reviewed, on January 23, 2008. The policy indicated the facility used the Broselow system for treatment of pediatric emergencies in all areas where pediatric patients were cared for, "to standardize pediatric emergency care," and, "to rapidly identify medication .... dosages for the pediatric patient."
The Broselow system was developed to increase the accuracy of weight estimation using height-weight correlations from the National Center for Health Statistics. The system provides a tool for determining the correct dosage of medications and equipment sizes for use in a pediatric emergency, based on the length of the child.

The system includes a color coded tape combined with a cart (or a bag). The colors on the tape correlate with drawer colors on a cart (or pocket colors in a bag). The tape supplies information regarding equipment/supply sizes and medication doses for children in emergency situations. The cart (or bag) contains equipment and supplies in the sizes needed for children. The colors on the drawers (or pockets) match the colors on the tape, and each color represents a different sized child.

The tape is laid next to the child, starting at the head and ending at the feet. The color, or "zone" on the tape that is next to the child's feet contains information regarding equipment, supplies, and medication doses to use for a child that length. Whatever color the child's feet falls into is the color of the drawer (or pocket) that has the correlating sizes of equipment and supplies.

For example, if a child's length falls into the orange area of the tape, the orange drawer or pocket is opened for supplies and equipment, and the medication doses are contained in the orange area of the tape.
Continued From page 3

The Broselow system is effective only if the tape, the medications, and the cart/bag are immediately available.

During an interview with the Director of Performance Improvement (PI), on January 23, 2008, at 10:03 a.m., the director stated the facility had 22 deaths in the past three months, seven were pediatric patients. The director stated she was in the process of “backtracking” through the risk management information to see if there were any issues with the deaths.

During a tour of the Post Anesthesia Care Unit (PACU), on January 23, 2008, at 11:28 a.m., a Broselow bag was observed next to the crash cart. The pediatric medication tray located in the crash cart contained pediatric concentrations of Atropine (a drug used to treat a slow or absent heart beat) and Sodium Bicarbonate (a drug used to normalize the body's pH). The Atropine concentration was 0.05 mg/ml. The Sodium Bicarbonate concentration was 4.2%.

During a tour of the Emergency Department (ED), on January 23, 2008, at 11:52 a.m., a Broselow cart was observed in the trauma room. The pediatric medication tray located in the cart contained pediatric concentrations of Atropine and Sodium Bicarbonate. The Atropine concentration was 0.05 mg/ml. The Sodium Bicarbonate concentration was 4.2%.

During a tour of the medical surgical unit, on January 23, 2008, at 12:15 p.m., a Broselow cart
Continued From page 4

was observed next to the crash cart. The pediatric medication tray located in the crash cart contained pediatric concentrations of Atropine and Sodium Bicarbonate. The Atropine concentration was 0.05 mg/ml. The Sodium Bicarbonate concentration was 4.2%.

During a tour of the Radiology department, on January 23, 2008, at 12:40 p.m., a Broselow bag was observed sitting on a cart in the hallway. The department crash cart contained a pediatric medication tray with pediatric concentrations of Atropine and Sodium Bicarbonate. The Atropine concentration was 0.05 mg/ml. The Sodium Bicarbonate concentration was 4.2%.

The Broselow tape was reviewed on January 23, 2008. According to the tape, drug doses to be administered to pediatric patients were calculated based on adult concentrations of Atropine (0.1 mg/ml) and Sodium Bicarbonate (8.4%). The tape indicated, "All dosage calculations are based on the concentrations recommended in the calculation basis. Use of any other drug concentrations will result in dosage error."

Further review of the facility’s Pediatric Code Cart policy, indicated the medication dosages for pediatric resuscitation were listed (on the Broselow tape) in milliliters (mls) to be given from adult dose syringes.

The facility had incorrect Atropine and Sodium Bicarbonate concentrations on their pediatric drug trays. Administering the amount of Atropine and...
Continued From page 5

Sodium Bicarbonate (in ml) listed on the Broselow tape would result in the child receiving half of the dose necessary to treat a life threatening emergency.

The failure of the facility to ensure correct concentrations of medications were supplied created a potential for administration of incorrect and ineffective drug doses and death during resuscitation of a pediatric patient.

T22 DIV5 CH1 ART3-70267 (a). Pharmaceutical Service Equipment and Supplies

(a) There shall be adequate equipment and supplies for the provision of pharmaceutical services within the hospital.

Based on observation, interview, and record review, the facility failed to ensure the availability of Broselow tapes where pediatric patients were cared for in the facility, resulting in the inability to determine the amount of medication to be given to a child during a life threatening emergency. The could result in potential death of the child.

Findings:

The facility's policy titled, "Code Cart: Pediatric" was reviewed on January 23, 2008. The policy indicated the facility used the Broselow system for treatment of pediatric emergencies in all areas where pediatric patients were cared for, "to standardize pediatric emergency care," and, "to
Continued From page 6

rapidly identify medication dosages for the pediatric patient."

Further review of the facility's Pediatric Code Cart policy indicated the following:

a) Pediatric patients requiring emergent interventions would be measured using the Broselow tape kept in the top drawer of the Broselow cart (or in the pocket of the Broselow bag), and;

b) Medication would be given using the tape to identify the appropriate dose.

1. During an interview with the Director of Performance Improvement (PI), on January 23, 2008, at 10:03 a.m., the director stated the facility had 22 deaths in the past three months, seven were pediatric patients. The director stated she was in the process of "backtracking" through the risk management information to see if there were any issues with the deaths.

During a tour of the ED on January 23, 2008, at 11:52 a.m., a Broselow cart was observed in the trauma room. A sign was observed, taped to the cart, dated January 16, 2008. The sign read, "Missing Broselow tape...they have been ordered."

During an interview with the Director of the ED on January 23, 2008, at 12 p.m., the Director stated if they were to have a child come in needing emergency care or resuscitation at that moment, they would not know what medication doses to give without the Broselow tape.
Continued From page 7

During an interview with ED Registered Nurse (RN) 1, on January 23, 2008, at 12:10 p.m., RN 1 stated he restocked the Broselow cart on January 16, 2008, and the Broselow tape was missing. The RN stated he believed in communication, so he taped the sign to the Broselow cart so the staff would know they did not have a Broselow tape to use for reference. The RN stated he ordered additional Broselow tapes on January 16, 2008, and the ED had been without the tape for seven days. The RN stated if a pediatric patient came in needing emergency care or resuscitation, he hoped the paramedic who brought the child in would have a Broselow tape, if the child came by ambulance.

During an interview with the Chief Operating Officer (COO) on January 23, 2008, at 12:04 p.m., the COO stated if any area had to be without a Broselow tape, it was "logical" for the ED since the other areas did not do pediatric resuscitations as often. The COO stated the other areas would need the tape worse if they had a pediatric code. She stated if anybody had to wait awhile to get a tape, she preferred it was the ED, because of their expertise.

During a return visit to the ED, on January 24, 2008, at 9:30 a.m., the Broselow cart was observed in the Trauma room with the sign still taped to it, indicating the Broselow tape was still missing.

During an interview with ED RN 2, on January 24, 2008, at 9:34 a.m., RN 2 stated she was not aware the tape was missing. RN 2 stated she did not
Continued From page 8

know what she would do if they were to receive a pediatric patient in need of emergency care or resuscitation, as she relied on the Broselow tape for pediatric medication dosing.

During an interview with the ED physician on duty, on January 24, 2008, at 9:40 a.m., the physician stated the Broselow tape had been missing, "since last week." The physician stated it was a problem because the staff relied on the tape for pediatric medication dosing.

2. During a tour of the Radiology department on January 23, 2008, at 12:40 p.m., a Broselow bag was observed sitting on a cart in the hallway. No Broselow tape was found in the bag.

During a concurrent interview with the COO and the x-ray technician on duty, on January 23, 2008, at 12:43 p.m., the technician stated he did not know what the Broselow system was. Both the technician and the COO were unable to locate a Broselow tape in the department to be used with the bag.

The facility's failure to have a Broselow tape accompanying the Broselow cart in the ED, and the Broselow bag in radiology resulted in staff involved in emergency care and resuscitation of pediatric patients in these areas not having a mechanism to determine the medication doses to administer to a child in a life threatening situation.

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>T22</td>
<td>DIV5</td>
<td>CH1</td>
<td>ART6-70417. Basic Emergency</td>
<td></td>
</tr>
</tbody>
</table>

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.
## Medical Service, Physician on duty, Equipment and Supplies

All equipment and supplies necessary for life support shall be available, including but not limited to, airway control and ventilation equipment, suction devices, cardiac monitor defibrillator, pacemaker capability, apparatus to establish central venous pressure monitoring, intravenous fluids and administration devices.

Based on observation, interview, and record review, the facility failed to ensure the availability of a Broselow tape and pediatric airway equipment in the ED, resulting in the inability to provide an airway, and the potential for death in a child weighing 32 - 34 kg.

### Findings:

The facility's policy titled, "Code Cart: Pediatric" was reviewed on January 23, 2008. The policy indicated the facility used the Broselow system for treatment of pediatric emergencies in all areas where pediatric patients were cared for, "to standardize pediatric emergency care."

Further review of the facility's Pediatric Code Cart policy indicated the following:

- a) Pediatric patients requiring emergent interventions would be measured using the Broselow tape kept in the top drawer of the Broselow cart (or in the pocket of the Broselow bag), and;
b) The measurement would be identified by color, and the appropriate corresponding drawer on the cart (or pocket in the bag) would be opened.

1. During an interview with the Director of PI, on January 23, 2008, at 10:03 a.m., the director stated the facility had 22 deaths in the past three months, seven were pediatric patients. The director stated she was in the process of “backtracking” through the risk management information to see if there were any issues with the deaths.

During a tour of the ED on January 23, 2008, at 11:52 a.m., a Broselow cart was observed in the trauma room. A sign was observed taped to the cart dated January 16, 2008. The sign read, “Missing Broselow tape and green intubation module. They have been ordered.”

During an interview with the Director of the ED, on January 23, 2008, at 12 p.m., the Director stated if they were to have a child come in needing emergency care or resuscitation, they would not know what equipment sizes to use without the Broselow tape. The Director also stated they would not be able to intubate (insert an airway) a child whose size correlated with the green drawer.

During an interview with ED RN 1, on January 23, 2008, at 12:10 p.m., the RN stated he restocked the Broselow cart on January 16, 2008, and the Broselow tape and green intubation module were missing. The RN stated he believed in communication, so he taped the sign to the
Continued From page 11

Broselow cart so the staff would know they didn't have a Broselow tape to reference for intubation supplies for a child whose size correlated with the green zone. The RN stated he ordered additional Broselow tapes and a green zone intubation module on January 16, 2008, and the ED had been without them for seven days. The RN stated if a pediatric patient came in needing emergency care or resuscitation, he hoped the paramedic who brought the child in would have a Broselow tape, if the child came by ambulance.

During an interview with the COO, on January 23, 2008, at 12:04 a.m., the COO stated if any area had to be without a Broselow tape, it was "logical" for the ED since the other areas didn't do pediatric resuscitations as often. The COO stated the other areas would need the tape worse if they had a pediatric code. She stated if anybody had to wait awhile to get a tape, she preferred it was the ED because of their expertise. The COO stated she was unaware the ED did not have the supplies needed for intubating a child whose size correlated with the green zone.

During a return visit to the ED, on January 24, 2008, at 9:30 a.m., the Broselow cart was observed in the Trauma room with the sign still taped to it, indicating the Broselow tape and green intubation module were still missing.

During an interview with ED RN 2, on January 24, 2008, at 9:34 a.m., the RN stated she was not aware the tape was missing. RN 2 stated she didn't know what she would do if they were to
Continued From page 12

receive a pediatric patient in need of emergency care or resuscitation, as she relied on the Broselow tape for pediatric equipment and supply sizes.

During an interview with the ED physician on duty, on January 24, 2008, at 9:40 a.m., the physician stated the Broselow tape had been missing, "since last week." The physician stated it was a problem because the staff relied on the tape for pediatric equipment and supply sizes. The physician also stated he didn't know what he would do if he needed to intubate a child whose size correlated with the green zone.

2. During a tour of the Radiology department on January 23, 2008, at 12:40 p.m., a Broselow bag was observed sitting on a cart in the hallway. No Broselow tape was found in the bag.

During a concurrent interview with the COO and the x-ray technician on duty, on January 23, 2008, at 12:43 p.m., the technician stated he did not know what the Broselow system was. Both the technician and the COO were unable to locate a Broselow tape in the department to be used with the bag.

The facility's failure to have a Broselow tape accompanying the Broselow cart in the ED, and the Broselow bag in radiology, resulted in staff involved in emergency care and resuscitation of pediatric patients in these areas, not having a mechanism to determine the medication doses to administer to a child in a life threatening situation.
Without the intubation module for a child whose size correlated with the green zone on the Broselow tape, the physician in the ED had no immediate mechanism to obtain and secure an airway for a child weighing 32 - 34 kg, who was having difficulty breathing or who had stopped breathing.

The above findings identified the facility's failure to provide the correct concentrations of emergency medications for pediatric resuscitation; failure to ensure a full complement of intubation supplies for children of all ages; and failure to ensure the availability of Broselow tapes (the resource tool) needed to determine the correct dose of emergency medications to administer based on the size of the child.

These failures caused or were likely to cause, serious injury or death in pediatric patients who needed emergency care and/or resuscitation.

The team met and discussed the above findings, on January 24, 2008, at 9:45 a.m., and determined that the deficient practice met the criteria for Immediate Jeopardy. The Chief Executive Officer and Chief Operating Officer were notified of the Immediate Jeopardy (IJ) on January 24, 2008, at 9:55 a.m. The facility was requested to provide a plan of correction to address the IJ.

On January 24, 2008, at 1:30 p.m., an acceptable plan of correction was received from the facility, which consisted of:
Continued From page 14

a. Obtaining additional Broselow tapes and placing one with each Broselow cart (or bag);

b. Replacement of pediatric emergency medications with the correct concentrations;

c. Obtaining and restocking pediatric airway supplies;

d. Addition of a back up inventory of Broselow tapes and supplies to be kept on hand, at all times in Materials Management;

e. Implementation of daily checks of Broselow carts and bags throughout the facility to ensure tapes and supplies were available and ready for use wherever pediatric patients were cared for;

f. Education and competency verification for all RNs and ED physicians in pediatric resuscitation, use of the Broselow system, and acquisition of tapes and supplies to ensure a complete system was in place in all areas where pediatric patients were cared for, and;

g. Monthly rounds by department managers to assess the knowledge of staff, regarding pediatric resuscitation and use of the Broselow system.

The CEO and COO were notified that the Immediate Jeopardy was abated on January 24, 2008, at 1:30 p.m.