The following reflects the findings of the California Department of Public Health during the investigation of complaints (CA00195114, CA00196637, and CA00200638), conducted from July 16, 2009, through September 2, 2009.

Representing the Department of Public Health:
- HFEN, Medical Consultant
- HFES

The Department substantiated violations of the regulations.

Abbreviations used in this document:
- CA: Cancer
- CHF: Congestive Heart Failure
- cm: Centimeter
- COPD: Chronic Obstructive Pulmonary Disease
- COS: Chief of Staff
- CT: Computerized Tomography
- DMS: Director of Medical Staff
- DQS: Director of Quality Services
- ER: Emergency Room
- H & P: History and Physical
- MSC: Medical Staff Coordinator
- P & P: Policy and Procedure
- ICU: Intensive Care Unit
- OR: Operating Room
- R: Right
- RN: Registered Nurse
- RT: Right
- TO: Telephone Order

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## Statement of Deficiencies and Plan of Correction

**CAUCHORNICA HEALTH AND HUMAN SERVICES AGENCY**

**DEPARTMENT OF PUBLIC HEALTH**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
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<tr>
<th>PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER</th>
<th>MULTIPLE CONSTRUCTION</th>
<th>DATE SURVEY COMPLETED</th>
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**NAME OF PROVIDER OR SUPPLIER**

PARKVIEW COMMUNITY HOSPITAL MEDICAL CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

3865 JACKSON STREET, RIVERSIDE, CA 92503 RIVERSIDE COUNTY

### Summary Statement of Deficiencies

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Continued From page 1

A 014 1280.1 (c)

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 ART3-70223 (b) (1) Surgical Service General Requirements

(b) A committee of the medical staff shall be assigned responsibility for:

1. Recommending to the governing body the delineation of surgical privileges for individual members of the medical staff. A current list of such privileges shall be kept in the files of the operating room supervisor.

2. Development, maintenance and implementation of 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.

DIV5 CH1 ART7-70707 (b) (5) Patients' Rights

(b) A list of these patients' rights shall be posted in both Spanish and English in appropriate places within the hospital so that such rights may be read by patients. This list shall include but not be limited to the patients' rights to:

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(5) Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.

Based on interviews, record, and facility document reviews, the facility failed to ensure:

1. The medical staff P&P, "Clinical Privileges," was implemented for the delineation of surgical privileges for Surgeon A to perform kidney surgery. This failed practice led to Surgeon A performing a right radical nephrectomy (removal of a kidney) on Patient A, when he was not granted privileges for kidney surgery.

2. The P & P, "Universal Protocol: Prevention Of Wrong Patient, Wrong Procedure, Wrong Site Surgery / Procedure," was implemented. This failed practice led to the surgical removal of wrong kidney, (the healthy right kidney) from Patient A.

3. Patient A's right to receive sufficient information about his proposed course of treatment in his primary language (Spanish) was protected in order to give an informed consent and understand the risks of surgical intervention, or to refuse treatment. This failed practice potentially led to Patient A's mistakenly signing a consent for removal of the

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**Continued From page 3**

Incorrect (right) kidney.

This event constituted an Immediate Jeopardy because the facility’s failures caused, or were likely to cause, serious injury or death to the patient, pursuant to Section 1280.1(c).

**Findings:**

The Department was notified by the facility of an adverse event that occurred on July 15, 2009, at 3:37 p.m., indicating, "a surgical procedure, a right radical nephrectomy, was performed on (Patient A) on July 14, 2009. The intended surgical procedure that should have occurred was for a left radical nephrectomy."

On July 16, 2009, at 9:30 a.m., an interview was conducted with the DQS. The DQS stated, "I was called by the pathologist on July 14, 2009, around 4 p.m. She (the pathologist) stated she was looking at a specimen labeled right kidney, when she couldn’t find a tumor, we both looked at it and saw no tumor. We then went to the OR, the patient (Patient A) was in the ICU, we did a cursory review of the record and determined an error was made. We called [the surgeon] he returned immediately. I took the chart into the OR conference room. We had the DSS and [the surgeon] review the chart. [The surgeon] couldn’t understand how it happened... He said, "it’s my mistake, I take full responsibility."

An interview was conducted with the DMS on July 16, 2009, at 12:20 p.m. The DMS stated, "[Surgeon] said, "It’s my mistake, I take full responsibility.""

**Monitoring/Responsible Person(s):**

- **Numerator:** Practitioners with privilege to perform scheduled procedure
- **Denominator:** Practitioners scheduled for surgical procedures

**Compliance Rate:** 100%

**Responsible Person(s):**

- Director of Surgical Services
- Director of Medical Staff Services

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Continued From page 4

A] at the time of this surgery did not have specific privileges for kidney surgery. He has privileges for general surgery and vascular surgery. This was a clerical oversight. He had privileges in 2003 and when he was re-appointed in 2005, the privileges for kidney surgery were not pulled over.

An interview was conducted with the COS regarding Surgeon A's lack of specific privileges for kidney surgery on July 16, 2009, at 12:30 p.m. The COS stated, "We came to know about the lack of privileges today. We made the decision not to suspend him (Surgeon A). We don't have all the facts. He is well respected."

A review of the medical staff P & P, "Clinical Privileges," was conducted on July 16, 2009. The policy indicates, "A practitioner providing clinical privileges at this hospital shall be entitled to exercise only those clinical privileges specifically granted. Privileges granted to practitioners shall be evaluated on the basis of the member's education, training, experience and demonstrated current clinical competence, subject to approval by the appropriate Department Chair, Credentials Committee, Medical Executive Committee and Board of Directors."

An interview was conducted with Surgeon A on July 16, 2009, at 2 p.m. Surgeon A stated, "I didn't realize I wasn't credentialed [having clinical privileges to perform specific medical and/or surgical procedures]."

An interview was conducted with the MSC on July 16, 2009, at 2:30 p.m.

### Action Plan – Universal Protocol

1. The Operating Room Staff has been inserviced on the Universal Protocol to prevent the recurrence of a surgical procedure being performed on the wrong body part.

2. The surgical site / side are verified with the following:
   - Diagnostic exams / procedures
   - Patient and / or family
   - Order for consent / Consent
   - Consultation Reports

3. In the event that diagnostic films or Picture Archiving System images are not available, then a transcribed radiology report of the exam must be present on the chart and used for verification of the surgical site / side.
Continued From page 5

16, 2009, at 1:15 p.m. The MSC stated, "[Surgeon A] has not had privileges for kidney surgery since 2003. The OR keeps a binder with all physician privileges. The OR didn't question it."

An interview was conducted with the DSS on July 18, 2009, at 2:10 p.m. The DSS stated, "Whenever there is a surgeon who will be doing a different procedure, we check his privileges."

An interview was conducted with RN 2 on July 16, 2009, at 2:15 p.m. RN 2 stated, "I wouldn't have checked [Surgeon A's] credentials. He is here so often. I would only check if he was a new physician."

A review of Patient A's record was conducted on July 16, 2009. Patient A was admitted to the facility via the ER on June 27, 2009, with a complaint of shortness of breath. Patient A was diagnosed with CHF (congestive heart failure,) and COPD, (chronic obstructive pulmonary disease.) The patient also had a history of diabetes. The patient was assessed as Spanish speaking.

On June 29, 2009, a renal (kidney) ultrasound (x-ray) was completed. The renal ultrasound result indicated Patient A had a left renal cyst.

On July 3, 2009, a CT (x-ray), of the chest was completed. The results indicated a 4.3 by 5.3 cm left renal mass. The final report indicated that the findings were reported by telephone to the facility at 5:10 p.m. on July 3, 2009.

Continued from Page 5

A 014 1280.1(c)
T22 DIV5 CH1 ART3-70223 (b) (1)
Surgical Service General Requirements

4. All members of the surgical team must respond verbally and agree with the stated side / side.

5. Operating Room nurses were:
   a. Trained and given access to the Picture Archiving System.
   b. Instructed and required to access and display, prior to surgical incision, diagnostic information related to the planned surgical procedure.

6. The World Health Organization Surgical Safety Checklist (First Edition) was implemented.

Monitoring/Responsible Person(s)

1. Operating Room Staff In-service 7.16.09

Numerator: Number of Operating Room Staff In-serviced on the Universal Protocol


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Continued from Page 6

Further record review indicated a surgical consult was completed on July 6, 2009, at 3:32 p.m. The impression noted, "Incidentally found right-sided renal tumor measuring 4 by 5 cm. CT of chest and abdomen otherwise negative for metastasis." The recommendations noted, "The patient will require a right radical nephrectomy. Due to his multiple comorbidities (additional diagnoses), he is at a high risk for postoperative complications..."

A review of the physician order sheet dated July 13, 2009, at 8:30 p.m. was conducted. The order noted, "Please obtain consent for right radical nephrectomy. T.O. [Surgeon A] RN 1." On the bottom left hand corner of the physician order was a box which was checked to indicate, "READ BACK."

An interview was conducted with Patient A's son on July 16, 2009, at 9:45 a.m. Patient A's son stated, "[Surgeon A] said now he [Patient A] will need dialysis, (procedure to filter the blood of impurities) two to three times a week for three to four hours at a time. My dad is not confused, he knows what is going on."

An interview was conducted with Patient A on July 16, 2009, at 11:45 a.m. Patient A's son interpreted. Patient A stated, "Before surgery they marked the right side. I didn't have a clue what side...they told me they found a tumor on the kidney, that they needed to remove it to avoid affecting the other one."

Continued From Page 7

Consent To Surgery Or Special Diagnostic Or Therapeutic Procedures, was conducted. Section 3 indicated, "Your physicians and surgeons have recommended the following operation or procedure, Right radical nephrectomy." The form was dated 7/13/09, Time, 2100, (9 p.m.), Signature: FT, [Patient A]."

An interview was conducted with Patient A's son on July 16, 2009, at noon. Patient A's son stated, "I translated the document, (the surgical consent) for him, (Patient A). I didn't know if the right or left side was correct. I assumed it was correct."


A review of the Preoperative Surgical/Procedure Checklist, was conducted on July 16, 2009. The section which indicated, "Order and Consent verified with Patient, x-rays, other Data," was circled, "Yes." The section which indicated "Surgical Site/Slide Verification," was reviewed. The section which indicated "Site/Slide confirmed with, patient, surgeon," was blank. The "Side" was circled, "Right."

A review of the Intraoperative Nursing Record dated July 14, 2009, was conducted. The operation started at 7:49 a.m. and ended at 9:18 a.m. The "Operative Procedure: Right Radical Nephrectomy." The section of the Nursing Record which indicated, "Operative Procedure: Right Radical Nephrectomy."
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
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<td>&quot;Operative Site,&quot; was verified as &quot;R.&quot; The surgical time out indicated, &quot;Surgical Site confirmed.&quot;</td>
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<td>A review of the Anesthesia Record dated July 14, 2009, at 7:25 a.m., was conducted. The pre-op diagnosis indicated,</td>
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<td>&quot;Rt. Kidney CA.&quot; The operation performed indicated, &quot;Rt radical nephrectomy.&quot;</td>
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<td><strong>Patient Rights</strong></td>
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<td>Wrong Site Surgery / Procedure,&quot; was conducted on July 16, 2009, at 5 p.m. The P &amp; P indicated the following:</td>
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<td>2. The Consent form is reviewed in the Preoperative area with the patient and/or patient's representative.</td>
<td>7.16.09</td>
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<td>&quot;Responsibility: Registered Nurse, Surgical/ GI Lab Technician, Radiology Technician, Anesthesiologist, Surgeon,</td>
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<td>3. The consent and procedure is verified in the Operating Room in accordance with the World Health Organization Surgical Safety</td>
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<td>Endoscopist, Physician.&quot;</td>
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<td>Checklist.</td>
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<td>&quot;Purpose 1. To ensure that all of the relevant documents and studies are available prior to the start of the</td>
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<td></td>
<td>4. The patient's primary language is identified during the Initial Patient Assessment.</td>
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<td>procedure and that they have been reviewed and are consistent with each other, with the patient's expectations,</td>
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<td>5. Hospital staff and/or the AT&amp;T Language Line Services are utilized for translation services. Family members are not allowed to translate</td>
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<td>and with the team's understanding of the intended patient, procedure, site, position, and, as applicable, any implants or equipment needed for the procedure. Missing information or discrepancies must be addressed before starting the procedure. 2. To identify unambiguously the intended site of incision, insertion, or other procedure. 3. To conduct a final verification of the correct patient, procedure, site, position, and, as applicable, implants and/or equipment.&quot;</td>
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<td>for the staff and/or patient.</td>
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"Policy: 1.1 [The facility] will engage in an ongoing process of information gathering and verification, beginning with the determination to do the procedure, continuing through all settings and interventions involved in the pre-procedure preparation of the patient, up to and including the "time out" just before the start of the procedure."

"Procedure: Pre-Procedural Checklist 2.1.2 Use completed form to confirm that documents related to the procedure are available in the medical record (i.e., imaging studies, lab results, consents, H & P, etc.) Pre-Procedural Verification Process 2.2.5 Following the verification of the patient's name identification, the licensed staff verifies the presence of the patient's ID band and the accuracy of the patient's name and medical record number. The information given by the patient is also verified against other information available about the procedure such as the surgery schedule, the H & P, consent, physician's orders, and diagnostic films as applicable. 2.2.6 As part of the pre-anesthesia assessment process, the anesthesiologist also verifies the correct patient, procedure, and site with the patient / parent / guardian / agent as applicable and against one of the other documents available such as the consent, surgery schedule, physician's orders, H&P, or diagnostic films [x-rays]."

An interview was conducted with the DSS on July 18, 2009, at 5 p.m. The DSS stated, "We have never as a standard put up films for every 'sided' surgery."

A review of the nursing "Intensive Care Records,"


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dated June 28, at 8 p.m., June 29, at 8 a.m., and June 30, at 8 p.m. indicated Patient A was alert and oriented to his name, the date, time, and to the situation.

A review of Patient A's "Interdisciplinary Care Plan" was conducted on July 16, 2009. A problem, dated July 8, 2009, addressed, "Knowledge Deficit...Understand Plan of Care...Use Interpreter to explain."

A review of the facility's medical staff bylaws was conducted on July 16, 2009. Item 3.2 indicated, "Every department in which an invasive procedure is to be done, or investigational drugs are used, shall provide a written informed consent, which shall be explained to, read, understood and signed by the patient."

An interview was conducted with Surgeon A on July 16, 2009, at 2:45 p.m. Surgeon A stated, "The patient, (Patient A) may not have fully understood which kidney..."

There was no documented evidence that Patient A was provided information about his diseased left kidney, options, use of anesthesia, or possible risks and complications by a staff member. There was no documentation found to indicate a Spanish speaking clinician reviewed the consent Patient A signed for a right radical nephrectomy.

The facility's failure to implement policies and procedures for Medical Staff led to the removal of the incorrect kidney of Patient A. Further, it led to

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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NAME OF PROVIDER OR SUPPLIER
PARKVIEW COMMUNITY HOSPITAL MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
3865 JACKSON STREET, RIVERSIDE, CA 92503 RIVERSIDE COUNTY

(SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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ID SUMMARY STATEMENT OF DEFICIENCIES

Patient A's mistakenly signing a consent for removal of the incorrect kidney. This is a deficiency that has caused a serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of the Health and Safety Code Section 1280.1(c).

Patient Rights

Denominator: Number of consents

Number of Random Chart Reviews: 70

Compliance Rate: 100%

Responsible Person(s): Directors, Nursing Departments

Continued from Page 11

A 014 1280.1(c)
T22 DIV5 CH7 ART7-70707 (b) (5)

7.16.09

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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