

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/19/2016
NAME OF PROVIDER OR SUPPLIER DESERT REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 N Indian Canyon Dr, Palm Springs, CA 92262-4872 RIVERSIDE COUNTY		
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	<p>The following reflects the findings of the Department of Public Health during an inspection visit:</p> <p>Complaint Intake Number: CA00462998 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 1899, HFEN</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>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.</p> <p>Health and Safety Code section 1280. (3) (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</p>		<p>The plan of correction is prepared in compliance with federal regulations and is intended as Desert Regional Medical Center's (the "hospital") credible evidence of compliance. The submission of the plan of correction is not an admission by the facility that it agrees that the citations are correct or that it violated the law.</p> <p>Organization Minutes: The confidential and privileged minutes are being retained at the facility for agency review and verification if required.</p> <p>Exhibits: All exhibits including revisions to Medical staff Bylaws, reviewed/revised or promulgated policies and procedures, documentation of staff and medical staff training/education are retained at the facility for agency review and verification upon request.</p> <p>Policy & Procedures: The Chief Nursing Officer and the Director of Clinical Quality Improvement reviewed and revised the Protocol: Transport of Monitored Patients previously revised in August 2014. The review found that the intent of the protocol, to enable registered nurses to utilize clinical criteria to discontinue telemetry for select patients for transport to and during a test, was not clearly articulated.</p>	10/27/15

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

CEO

9/21/17

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 8

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.

acceptable POC 9/25/17 2.P. APC [Signature] HFES 9/27/17

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	<p>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.</p> <p>Planning and Implementing Patient Care, Title 22, Division 5, Chapter 1, Article 3, Section 70215 (a) (2) and (b):</p> <p>(a) A registered nurse shall directly provide:</p> <p>(2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation.</p> <p>(b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission. Nursing Service Policies and Procedures. Title 22, Division 5, Chapter 1, Article 3, Section 70213(a) and (e)</p> <p>(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.</p>		<p>The Director of Clinical Quality Improvement revised the protocol to clearly include the clinical parameters for patients who must be escorted by a registered nurse to and from remote testing locations. Additional revisions were made by the CNO to reflect current practice. The revised Protocol was discussed with the Cardiology Section Chair and the Chief of Staff. The Protocol was then placed on the policy approval pathway and approved at Document Control Committee on January 22, 2016, the Medical Care Policy Committee on January 27, 2016, and the Medical Executive Committee on February 2, 2016 and approved by the Governing Board on February 8, 2016.</p> <p>Other Corrective Actions: At the close of the initial CDPH complaint investigation, the Director of Clinical Quality Improvement sent a memo to all Nursing Directors with telemetry capabilities that the current Protocol: Transport of Monitored Patients needed revision and while this process occurred, and effective immediately, the registered nurse must obtain a physician's order for a telemetry patient to be transported to a remote test without telemetry monitoring.</p>	<p>3/18/16</p> <p>2/8/16</p> <p>10/27/15</p>

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	<p>(e) 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>Based on interview and record review, the facility failed to ensure Patient 1, who was on telemetry monitoring (continuous cardiac/heart monitoring per a physician's order), continued to be monitored during transportation to a Magnetic Resonance Imaging procedure and was accompanied by a Registered Nurse (RN) per facility protocols (MRI-a type of x-ray). The failure to monitor the patient's heart had the potential to prevent the identification and treatment of an irregular heart rhythm which may have contributed to the patient's death, as Patient 1 had a cardiac arrest as he was transported out of the MRI room.</p> <p>Findings:</p> <p>A review of Patient 1's clinical record was conducted. The record revealed on October 6, 2015, at 2:57 p.m., the paramedic ambulance responded to Patient 1's home where he was found on the floor. At that time the patient's vital sign monitor indicated he was experiencing atrial fibrillation (an irregular heart rhythm). Patient 1 was transported by ambulance to the facility and was subsequently admitted on October 6, 2015, at 3 p.m.</p> <p>The document entitled, " History and Physical" dated October 6, 2015, indicated Patient 1 was to</p>		<p>In addition, a memo was sent to hospital administration, directors, managers regarding the change and the requirement that all patients on telemetry monitoring are to be transported on telemetry monitoring with a registered nurse, unless a physician order is obtained allowing patient transport without Telemetry.</p> <p>The Chief of Staff sent a memo to the members of the medical staff "Telemetry Transport" regarding the changes to transport of telemetry patients stating that "all patients on telemetry will be accompanied during transport by an RN and will be transported on a monitor" and the process for a physician's order to transport a patient without telemetry monitoring.</p> <p>The Nursing Directors of 2 Sinatra and 3 Sinatra (Telemetry Units) met with the Manager, Accreditation and Regulation and developed a one-page guideline for nursing documentation on all Telemetry units, "Transport Documentation of Telemetry Patients." The document provides guidance to nursing staff in the EHR location and the "who, what, when, where and why" content of nursing documentation for patients transported with telemetry monitoring.</p>	<p>3/15/16</p> <p>3/18/16</p> <p>3/31/16</p>

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	<p>be admitted for observation, telemetry monitoring, serial electrocardiograms (ECG-monitoring of the hearts electrical rhythms), and cardiac enzymes (blood studies). Further record review indicated the following:</p> <p>On October 6, 2015, at 4:16 p.m. Patient 1 had an ECG conducted. The result indicated, "Abnormal Rhythm ECG."</p> <p>On October 7, 2015, at 12:24 a.m. and at 6:03 a.m., two ECGs were conducted. The results both indicated, "Abnormal ECG."</p> <p>Patient 1's cardiac rhythm analysis dated October 7, 2015, at 6 a.m., indicated the patient had an irregular heart rhythm.</p> <p>The nurse's note dated October 7, 2015, at 7:30 p.m., indicated Patient 1 had an irregular cardiac rhythm, trigeminy (an irregular heart rhythm in which there is a group of three beats, usually one normal beat followed by two extra beats). The notes indicated the nurse notified the physician and received an order to place the patient on continuous oxygen at 2 liters per minute.</p> <p>The nurse's note dated October 7, 2015, at 9:30 p.m., indicated Patient 1 continued to have an irregular heart rhythm, and was having frequent irregular heartbeats.</p> <p>The nurse's note dated October 8, 2015, at 1:01 a.m., indicated Patient 1 was taken off telemetry monitoring to be transported for a MRI of the head.</p>		<p><u>Training:</u> The Director of Clinical Quality Improvement discussed the current Protocol: Transport of monitored Patients, the memo requiring a physician's order for transport without telemetry and the proposed revisions to the Protocol at the November 5, 2015 meeting of the Nursing Executive Council. Each Nursing Director then reviewed this information with their unit charge nurses at each nursing unit's Lean Daily Management Huddle to ensure communication to all registered nursing staff. The Directors' of Radiology, Cardiology Services, and Respiratory Therapy were also education on the protocol change so that their staff could assure that telemetry patients were properly transported, and telemetry maintained throughout the testing process.</p> <p>After Governing Board approval of the revised Protocol: Transport of Monitored Patients, the Nursing Directors of units with telemetry monitoring: 2 Sinatra Progressive Care, 3 Sinatra Progressive Care and the Intensive Care Units were provided the revised protocol to immediately share and educate their charge nurses, clinical managers and registered nursing staff.</p>	<p>11/5/15</p> <p>2/9/16</p>	

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	<p>The documentation failed to show that the patient's physician was consulted, or a physician's order to disconnect the telemetry monitoring was obtained in order to transport the patient for the MRI.</p> <p>An interview was conducted with the MRI Technologist, (MRT), on December 8, 2015, at 6 p.m. The MRT stated Patient 1 did not have an RN accompanying him and the patient was not connected to a telemetry monitor when the patient was brought to the MRI area by the transporter staff. The MRT further stated he called the telemetry floor to get report on the patient, and asked the nurse (Registered Nurse, RN 1) if the patient needed monitoring. The MRT stated, "She (RN 1) said no."</p> <p>The MRT stated when Patient 1 was initially advanced into the MRI the patient asked to be brought out, and stated he was short of breath. The MRT then pulled the patient out of the MRI, sat the patient up and placed high flow oxygen on him. The MRT further stated after speaking with the patient he agreed to attempt the procedure again, so the MRT advanced him into the MRI for the second time, but again the patient asked to be pulled out. Patient 1 remained unmonitored during his time in the MRI area.</p> <p>The MRT stated he told Patient 1 he would not be able to continue the procedure at that time. The MRT stated he rolled the patient back out into the hall and as he was assisting the patient onto his bed the patient became non responsive. The MRT stated he called the operator and used the overhead system to call a code blue (cardiac arrest), the</p>		<p>The Directors of Telemetry units and the Director of the Transporters met with the staff to review the deletion of the Protocol: Transport of Monitored Patients, and to stress that safe transport of monitored patients including requirements for a physician order to transport off of telemetry.</p> <p>Additional training was provided to all Nursing Directors with Telemetry beds on their units reviewed the March 15, 2016 memo regarding the discontinued protocol at the Lean Daily Huddles, and reviewed with individual staff. The Assistant Chief Nursing Director discussed this change with the clinical managers, directors, and administrators at the hospital Safety Huddle.</p> <p>All registered nurses who worked on a unit with telemetry monitoring were required to complete the EKG education and competency exam from the intranet company-wide approve Health Stream education site. This education included recognizing EKG changes of varied abnormal EKG rhythms that compose one of three versions of the competency test.</p> <p>All registered nurses who work on units with telemetry monitoring are annually assigned to complete the EKG education and competency.</p>	<p>4/1/16</p> <p>3/16/16</p> <p>Began 2015 and ended 3/15/16</p> <p>4/1/16</p>

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	<p>crisis team responded quickly, began life saving procedures, but Patient 1 died.</p> <p>Record review failed to show that the MRT notified Patient 1's RN, or contacted the patient's physician to notify them of the patient's shortness of breath or that he had increased the patient's oxygen. There was no documentation that indicated Patient 1 was assessed after he experienced shortness of breath</p> <p>An interview with the Radiology (x-ray) Manager (RM) was conducted on December 9, 2015, at 8:10 a.m. The RM stated "We (x-ray staff) do not monitor patients (when having an MRI), the nurse does."</p> <p>A review of the document titled "Discharge Summary" dated October 8, 2015, at 2:29 a.m., indicated Patient 1 was declared dead at 1:52 a.m., on October 8, 2015. The cause of death was listed as cardiac arrest (the heart stops beating).</p> <p>RN 1, responsible for the care of Patient 1 on October 8, 2015, at 1 a.m., was interviewed on December 8, 2015, at 1:50 p.m. RN 1 stated earlier during her shift she was informed that Patient 1 had an episode of bigeminy (an irregular heart rhythm where normal sinus beats alternate with premature ventricular beats).</p> <p>RN 1 stated she called Patient 1's physician on October 8, 2015, and the physician stated the patient could leave the unit in order to have the MRI.</p> <p>There was no documentation that indicated Patient 1's physician was notified the patient would be</p>		<p><u>Monitoring:</u> The One Call Center Manager and the Nursing Supervisors concurrently reviewed the fulfillment of each request to assure that 100% of telemetry patients who required telemetry were accompanied by a telemetry certified registered nurse. The Nursing Directors concurrently reviewed all patient transports of telemetry patients for the presence of a physician's order for transport without telemetry. The Director Clinical Quality Improvement or designee reported any events to the Quality Council each month for review and action as required.</p> <p>The Education Coordinator provided a report to the Nursing Directors of Telemetry units on the completion and exam passing results for all registered telemetry nurses. The EKG Health Stream education site assignment is mandatory therefore suspension was required for registered nurses not completing the course and exam.</p> <p><u>Responsible Person(s):</u> Chief Nursing Officer Director of Clinical Quality Improvement Nursing Directors of 2 Sinatra, 3 Sinatra, and Intensive Care. Assistant Chief Nursing Officer</p>	

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	<p>transported to have a MRI without a telemetry monitor.</p> <p>An interview was conducted with the Clinical Manager, (CM) 1, of the telemetry unit on December 8, 2015, at 2 p.m. CM 1 stated Patient 1 did not have a normal ECG when he was taken off of the telemetry monitor to be transported for an MRI. CM 1 further stated the patient (Patient 1) should have been monitored and accompanied by a registered nurse.</p> <p>An interview was conducted with the Radiology Manager on December 9, 2015, at 8:30 a.m. The Radiology Manager stated if a patient is sent for an MRI without a telemetry monitor and without a nurse accompanying the patient, the radiology staff would not monitor the patient.</p> <p>A review of the facility policy, "Protocol: Transport of Monitored Patients (Last Revised: 8/5/14)," was conducted. The policy indicated: " Purpose: To provided safety during transport of patients. 3. For Telemetry patients, noted below are the parameters for those who must be escorted by an RN and those who do not require escort by an RN: Transport with RN...Arrhythmia (irregular heart rhythm)."</p> <p>An interview was conducted with the Chief of Staff on December 10, 2015, at 2:05 p.m. The Chief of Staff stated if a patient was on telemetry monitoring, the patient's physician should be consulted when the patient was to be transported for testing in order to determine if telemetry monitoring should or should not be continued during that time.</p>			

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	<p>The facility failed to ensure Patient 1's heart was monitored when transported to the x-ray department for a MRI. This failure had the potential to prevent the identification and treatment of an irregular heart rhythm which may have contributed to the patient's death.</p> <p>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).</p>			

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