

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2011
NAME OF PROVIDER OR SUPPLIER Kaweah Delta Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 W. MINERAL KING, VISALIA, CA 93291 TULARE COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>Continued From page 1</p> <p>T22 DIV5 CH1 ART3-70215(b) Planning and Implementing Patient Care</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.</p> <p>Based on staff interviews, clinical record review, and administrative document review, the hospital failed to ensure the delivery of patient care encompassed all aspects of the nursing process when:</p> <p>1) Nursing staff failed to recognize the need to taper Patient1's Total Parenteral Nutrition (TPN) prior to discontinuation in accordance with TPN order set and Hospital Policy and Procedure.</p> <p>2) Nursing staff failed to monitor the Patient1's blood glucose levels after discontinuation of TPN.</p> <p>3) Nursing staff failed to assess, develop and implement appropriate interventions, such as performing a finger stick blood glucose test, when the Patient was symptomatic for hypoglycemia.</p> <p>4) Nursing staff called the Hospital's Rapid Response Team Leader (RRTL) and then failed to provide adequate background information for the RRTL to assess and plan interventions appropriate to Patient 1.</p> <p>5) The hospital RRTL failed to ensure she had</p>		<p>The RCA findings and plan of correction were reported to the Board of Directors on 5/9/11. The findings of the RCA were presented to the Medical Care Review Committee (MCRC) on 6/1/11 and the Patient Safety Committee (PSC) on 7/20/11. Members of the MCRC include the chair/designee of all clinical departments, the Peer Review Committee (PRC) chair and the Medical Director of PI. Other MCRC attendees include the CEO, CMO, COO, Director of PI, Director of RM and other KDHCD and medical staff as determined by the chair. MCRC presented to Quality Council on 6/22/11. The care of Patient 1 was presented to Medical Executive Committee (MEC) on 6/1/11.</p> <p>3) The matter was referred for medical staff peer review for Physician 2. The care provided by Physician 2 was peer reviewed on 5/11/11.</p> <p>i. Persons Responsible: Chief of Staff, Peer Review Committee and MEC for oversight and ensuring proper adherence to Medical Staff bylaws, rules, regulations.</p> <p>ii. Monitoring process: Results and actions of peer review are confidential, privileged and protected pursuant to California Evidence Code 1157.</p> <p>4) The "Adult Parenteral Nutrition Order Set" was reviewed, revised and temporarily approved by the Chief of Staff on 4/28/11. Final approval of the policy was obtained by MEC on 6/15/11 and the Board of Directors on 7/25/11. Changes included:</p> <p>I. Sudden Discontinuation of Total Parenteral Nutrition (TPN)</p> <p>A. If a patient is receiving central TPN and administration of TPN is suddenly interrupted, infuse Dextrose 10% at same TPN rate and call physician for further orders.</p>	<p>5/9/11</p> <p>6/1/11 7/20/11</p> <p>6/22/11</p> <p>6/1/11</p> <p>5/11/11</p> <p>4/28/11</p>

Event ID: 81GR11

7/21/2011

2:17:43PM

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

Lindsay K. Munn

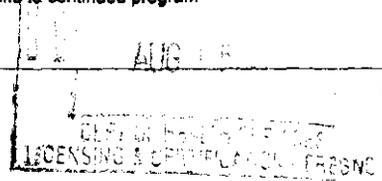
TITLE

CEO

(X6) DATE

8/15/11

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.



CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2011
NAME OF PROVIDER OR SUPPLIER Kaweah Delta Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 W. MINERAL KING, VISALIA, CA 93291 TULARE COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>Continued From page 2</p> <p>adequate Patient's history to assess and develop appropriate interventions for Patient 1.</p> <p>6) Nursing staff failed to advocate for Patient 1 when she became nonresponsive by activating the Rapid Response team.</p> <p>These failures resulted in Patient 1 lapsing into a hypoglycemic coma ending in the death of Patient 1.</p> <p>Findings:</p> <p>Patient 1 was admitted to the facility on [redacted]/11 for severe mid-epigastric abdominal pain. A surgical consultation note dated [redacted]/11 indicated "Computerized Tomography (CT) scan of the abdomen showed a hepatic flexure mass with regional lymphadenopathy." The hepatic flexure was the area of the colon, ascending colon, which bent to the left to from the transverse colon. Lymphadenopathy meant swollen lymph nodes. The postoperative note dated [redacted]/11 indicated Patient 1 had a right extended hemicolectomy with stapled ileo-transverse anastomosis (the ileum, a part of the colon, was connected to the transverse colon) and a Pancreatico-duodenectomy or a Whipple Procedure (a Whipple Procedure was the removal of all or part of the pancreas along with the duodenum). One of the functions of the Pancreas was to secrete:</p> <ul style="list-style-type: none"> * Glucagon -raises the level of glucose (sugar) in the blood, * Insulin-stimulates cells to use glucose, 		<p>II. Planned Discontinuation of Parenteral Nutrition (TPN and PPN)</p> <p>A. Decrease parenteral infusion rate by 50% for two hours and then discontinue infusion.</p> <p>B. Discontinue parenteral nutrition infusion only between the hours of 0700-1600 regardless of the volume of solution remaining, unless an alternative time is specifically ordered by the physician.</p> <p>C. Upon discontinuation of parenteral nutrition, bedside glucose monitoring every 30 minutes x2, then every 2 hours x 2. Notify physician if blood glucose level is less than 80mg/dL.</p> <p>III. Persons Responsible: Chief Nursing Officer (CNO) for assuring all nursing services are provided in compliance with regulatory requirements. Clinical Directors and Nurse Managers for ensuring nursing staff are competent in understanding & complying with policies & procedures and monitoring is completed. MEC, PRC and Chief of Staff for oversight and ensuring proper adherence to Medical Staff bylaws, rules & regulations. Monitoring process: Whenever TPN or PPN is discontinued (DC), the rate will be decreased by 50% for at least 2 hours and subsequent monitoring of blood sugars will be done. The following steps below are to be completed:</p> <p>A. Each shift the Team Lead (TL) will be responsible for monitoring the DC of patients on TPN/PPN. The bedside nurse will alert the TL when there is a need to DC TPN/PPN (i.e. MD order to DC TPN, patient to go to OR, patient transferred with new orders).</p> <p>B. DOUBLE VERIFICATION PROCESS: The TL will accompany the patient's nurse to the bedside where the rate will be: 1) Decreased by 50% 2) The bedside nurse will document the decrease of the rate by 50%</p>	

Event ID:81GR11

7/21/2011

2:17:43PM

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

Lindsay K. Munn

TITLE

CEO

(X8) DATE

8/15/14

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.



CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2011
NAME OF PROVIDER OR SUPPLIER Kaweah Delta Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 W. MINERAL KING, VISALIA, CA 93291 TULARE COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>Continued From page 3</p> <p>* Somatostatin may regulate the secretion of glucagons and insulin.</p> <p>In an article published by USC (University of Southern California) Center for Pancreatic and Biliary Diseases, titled "Surgical Techniques for Pancreas Preservation "accessed from the internet on 5/11/11, indicated the loss of pancreatic tissue after surgical removal "increases the risks for the development of diabetes mellitus and mal-absorption of food."</p> <p>On [REDACTED]/11 at 9:03 p.m., Physician orders indicated "Insulin drip to keep blood glucose between 80 - 120 mg/hr (mg/hr was how the order was written by the physician, blood glucose was measured in milligrams per deciliter or mg/dl) Accu check Q one hourly." This meant Patient 1's blood glucose was to be kept between 80 and 120 mg/dl (milligrams per deciliter) with 74 to 118 mg/dl being normal using the facility's reference range. These orders also indicated Patient 1 was to have hourly blood glucose checks. On [REDACTED]/11 at 11:14 a.m., Patient 1's Physician orders indicate Total Parenteral Nutrition (TPN), a solution containing all the required nutrients including protein, fat, calories, vitamins, and minerals, was injected over the course of several hours, into a vein. TPN provided a complete and balanced source of nutrients for patients who cannot consume a normal diet) with 25% Dextrose to be started at 60 milliliters (ml) per hour. On [REDACTED] 11, Physician 1 wrote an order to start subcutaneous insulin with bedside glucose monitoring to be done every 4 hours. The order was for 14 units of Lantus (a type</p>		<p>C. The bedside nurse will continue the weaning process — remove the TPN after 2 hours, monitor the blood sugar every 30 minutes X 2 and then every 2 hours x 2</p> <p>D. The bedside nurse will document that the TPN/PPN was DC'd</p> <p>E. The bedside nurse will dock the Point of Care blood glucose meter to ensure the results are timely downloaded into the electronic medical record (EMR)</p> <p>F. The bedside nurse will report to the TL when the entire TPN/PPN discontinuation process has been completed</p> <p>G. The TL by review of the bedside nurse's documentation will verify on the paper audit tool that all steps have been completed in accordance with policy and procedure</p> <p>H. The TL will immediately provide the completed audit tool to the Nurse Manager for review. Opportunities for improvement relative to nursing practice will be managed individually by the respective nursing manager with appropriate education and progressive discipline if indicated. Results to be monitored by the PI Department and reported to MCRC and Patient Safety Committee for a minimum of 4 months to assure compliance.</p> <p>I. This will continue for 4 months to assure compliance is achieved. If compliance is not achieved, the double verification process will continue until such time as there is 4 months of consecutive compliance.</p> <p>5) A Memo prepared by the Chief of Medical Staff was distributed to all Medical Staff on 4/29/11, educating Medical Staff on the changes to the ADULT PARENTERAL NUTRITION ORDER SET</p> <p>i. Persons Responsible: MEC, PRC and Chief of Staff for oversight and ensuring proper adherence to Medical Staff bylaws.</p>	4/29/11

Event ID: 81GR11

7/21/2011

2:17:43PM

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

TITLE

(X6) DATE

Lindsay K. Munn

CEO

8/15/11

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2011
NAME OF PROVIDER OR SUPPLIER Kaweah Delta Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 W. MINERAL KING, VISALIA, CA 93291 TULARE COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>Continued From page 4</p> <p>of insulin) in the morning and 14 units at bedtime. The order included "correction" insulin, a Novolog sliding scale, to be given if the blood glucose level was 150 milligrams per deciliter (mg/dl) or greater. The "Normal" reference range for blood glucose level per the Hospitals lab would be 74 to 118 mg/dl. On [redacted]/11 the insulin order was changed to Lantus 20 units Subcutaneous in the a.m. and 20 units subcutaneous in the p.m. On [redacted]/11 the p.m. Lantus dose was reduced to 10 units.</p> <p>Patient 1's Physicians orders, dated [redacted]/11, indicated Physician 2 ordered a change in blood glucose monitoring from every 4 hours (6 times per day) to ac (before meals) and hs (bedtime, for a total of 4 times per day).</p> <p>Patient 1's Physician's orders, dated [redacted]/11 at 9:22 a.m., indicated "Decrease TPN to 40 ml/hr"</p> <p>Physician's telephone orders from the Family Nurse Practitioner (FNP), dated [redacted]/11 at 3:00 p.m., indicated "D/C TPN after this bag."</p> <p>On 5/5/11 at 11:00 a.m., during an interview, Registered Nurse 1 (RN 1) indicated Patient 1's TPN was discontinued "somewhere between 9:30 p.m. and 10:00 p.m." RN 1 stated the TPN had not been tapered and had been running at 40 ml/hour all day long. The finger stick blood sugar (FSBS), (a test to measure the sugar or glucose in the body) was 134 at 9:00 p.m.</p> <p>RN 1 stated between the hours of 10:00 p.m. and 2:00 a.m. she believed Patient 1 was sleeping. At about 2:20 a.m. RN 1 was at the nurse's station</p>		<p>rules & regulations.</p> <p>ii. Monitoring process: Medical Staff Chain of Command is to be implemented immediately in cases where the physician writes an order to wean TPN for a patient who is receiving insulin if the physician does not use the ADULT PARENTERAL NUTRITION ORDER SET or if the physician writes/enters orders that are not consistent with KDMC policy (ie reduce TPN rate 50% for required period of time, or orders blood sugar checks as required). Cases which have identified opportunities for improvement will be referred to physician peer review as appropriate. Findings and actions of the PRC will be reported to MEC, for appropriate action.</p> <p>6) Beginning 4/28/11 and completed by 5/12/11, 100% KDMC nursing staff were re-educated via written materials and 1:1 stand-up in-service meetings on "Rapid Response Team (RRT)—Kaweah Delta Medical Center (Main Campus)" policy and procedure.</p> <p>i. Education content included evidenced-based, current practice skills required, and policy and procedure expectations for appropriate response to patients believed to be "at risk".</p> <p>ii. Persons Responsible: CNO for assuring all nursing services are provided in compliance with regulatory requirements. Clinical Directors, Nurse Managers and Clinical Educators for ensuring nursing staff are competent in understanding & complying with policies & procedures and monitoring is completed. Director of Emergency and Critical Care Services and RRT Medical Director for ensuring RRT monitoring is completed. MEC, PRC and Chief of Staff for oversight and ensuring proper adherence to Medical Staff bylaws, rules & regulations.</p>	5/12/11

Event ID:81GR11

7/21/2011

2:17:43PM

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

TITLE

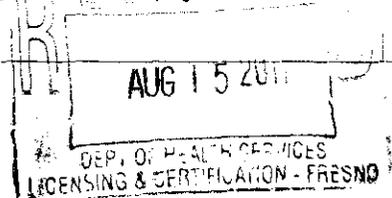
(X6) DATE

Lindsay K. Munn

CEO

8/15/11

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.



CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER Kaweah Delta Medical Center	STREET ADDRESS, CITY, STATE, ZIP CODE 400 W. MINERAL KING, VISALIA, CA 93291 TULARE COUNTY
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	--------------------

	<p>Continued From page 5</p> <p>when she heard Patient 1 repeating the same phrase. RN 1 found Patient 1 able to state her name and that she was in a hospital but could not name the correct hospital. Patient 1's vital signs were taken. Then the Rapid Response Team Leader (RRTL) was called. She did not activate the Rapid Response Team. RN 1 stated the RRTL asked what was going on with Patient 1. RN 1 told the RRTL Patient 1 had a change in level of consciousness (LOC). RN 1 stated she then called Physician 2, it was about 2:30 a.m. RN 1 stated she told Physician 2 the Patient had an abrupt change in LOC, was posturing and could state her name. Physician 2 ordered a Stat CT of the head, dated [redacted]/11 at 2:37 a.m. When asked if labs were ordered, RN 1 stated no other orders were received at that time. RN 1 stated a Finger Stick Blood Sugar (FSBS) was not done. RN 1 stated there were no FSBS done on her shift after the one done at 9:00 p.m. RN 1 stated Physician 2 arrived about 3:30 a.m. and called the Patient's family. At about 4:00 a.m. when all the family members were there, Physician 2 informed them of Patient 1's condition. RN 1 stated family changed Patient 1's code status to Do Not Resuscitate (DNR)(DNR means no chest compressions and no intubation to assist with a Patient's breathing). RN 1 stated she made the decision not to draw the morning labs or do the morning FSBS because Physician 2's DNR order included the statement "death is imminent."</p> <p>The facility policy and procedure titled, "Do Not Resuscitate" dated 6/26/10, indicated "V. A DNR order does not negate previous orders not related to CPR. ...IV. When a DNR order is written by a</p>		<p>iii. Monitoring process: 100% of RRT occurrences are monitored by the RRT committee (appropriate use of, process outcomes and clinical outcomes) and the KDMC PI Department. Results will be reported to MCRC and Patient Safety Committee for a minimum of 4 months to assure compliance. Consistent with the PI plan RRTs throughout KDHCD, are monitored monthly by the PI Department.</p> <ol style="list-style-type: none"> 1. An RRT form is completed by an RRT Nurse at the time of the RRT. The data entered into RRT database. All RRT forms are submitted to ICU Nurse Manager or designee for review within the next business day and evaluated for: <ol style="list-style-type: none"> 1) completeness of form, which includes data on LOC, blood glucose, and use of Dextrose 50% 2) appropriate use of Standardized Procedures based on assessment criteria and SBAR report received 3) timely response of physicians 4) completion of the debriefing with staff involved in the RRT. 2. If discrepancies exist, the ICU Nurse Manager will review with the RRT RN and the RRT Medical Director. 3. Aggregate data is presented at the RRT committee meetings monthly for analysis and actions as needed. 4. Beginning 9/1/11, RRTs that may have identified opportunities for improvement will be presented at the RRT committee monthly meetings to be analyzed for recommended and/implemented corrective actions. 5. Beginning 9/1/11, findings and actions of the RRT committee will be reported monthly to MCRC. RRT cases will be referred to physician and/or nursing peer review as appropriate. 	9/1/11
--	--	--	---	--------

Event ID: 81GR11

7/21/2011

2:17:43PM

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

TITLE

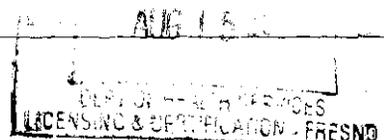
(X6) DATE

Lindsay K. Munn

CEO

8/15/11

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.



CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/03/2011
NAME OF PROVIDER OR SUPPLIER Kaweah Delta Medical Center			STREET ADDRESS, CITY, STATE, ZIP CODE 400 W. MINERAL KING, VISALIA, CA 93291 TULARE COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	<p>Continued From page 6</p> <p>physician, all previous orders not directly related to CPR stand as written and subsequent orders are not superseded. ...VI. If a patient's DNR order does not specify the category of medical intervention (Comfort Measures Only, Limited Additional Interventions, Full Treatment), then the patient will be treated as DNR with Full Treatment."</p> <p>On 5/5/11 at 11:45 a.m., during an interview, RRTL stated she was the Rapid Response nurse on the night of [redacted]/11 to the morning of [redacted]/11. RRTL stated she was called by RN 1 at about 2:00 a.m. to 2:30 a.m. on the morning of [redacted]/11. RRTL stated RN 1 told her Patient 1 had a hemicolectomy but was not told she had a Whipple procedure. She was also told Patient 1 was previously verbal, ambulatory (able to walk) and now had a change in LOC. The RRTL stated she performed an assessment of Patient 1 and found she was able to answer simple questions but was having difficulty talking or focusing. RRTL found Patient 1's hand grips weaker with the left hand and Patient 1 had a slight droop on the left side of her face. Patient 1's tongue, when extended, was midline (midline is a normal assessment). When questioned as to the time of this assessment, the RRTL stated it was done after the CT had been done. RRTL stated the CT had been done about 3:00 a.m. RRTL accompanied Patient 1 to get the CT ordered by Physician 2. RRTL stated Patient 1 deteriorated during this time and became unresponsive. Physician 2 was not called until Patient 1 was back on the floor. When questioned how RRTL knew Patient 1 was unresponsive, she stated she had performed a sternal rub (rubbing the</p>		<p>6. Opportunities for improvement relative to nursing practice will be managed individually by the respective nursing manager with appropriate education and progressive discipline if indicated.</p> <p>7) On 4/28/11, A Memo prepared by the Director of Nursing Practice was distributed to all licensed nursing staff on 4/28/11 regarding the RRT process.</p> <p>i. Persons Responsible: CNO for assuring all nursing services are provided in compliance with regulatory requirements. Clinical Directors Nurse Managers and Clinical Educators for ensuring nursing staff are competent in understanding & complying with policies & procedures and monitoring is completed.</p> <p>ii. Monitoring process: 100% of RRT occurrences are monitored by the RRT committee (appropriate use of, process outcomes and clinical outcomes) and the KDMC PI Department. Results will be reported to MCRC and Patient Safety Committee for a minimum of 4 months to assure compliance. Consistent with the PI plan, RRTs throughout KDHC, are monitored monthly by the PI Department. Process as described in detail in #7. Cases which have identified opportunities for improvement will be referred to nursing peer review as appropriate.</p> <p>8) Consistent with KDMC's commitment to ensure patient safety and quality care, beginning 4/28/11 and completed by 5/12/11, 100% KDMC nursing staff were immediately re-educated via written materials and 1:1 stand-up in-service meetings on altered level of consciousness (LOC), signs and symptoms of hypoglycemia and the "Hypoglycemia, Adult" CP.62 policy and procedure. Education content included evidenced-based, current practice skills required, and policy and</p>	<p>4/28/11</p> <p>5/12/11</p>	

Event ID:81GR11

7/21/2011

2:17:43PM

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

TITLE

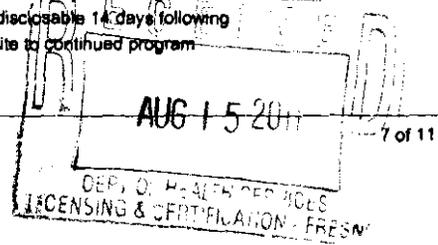
(X6) DATE

Lindsay K. Munn

CEO

8/15/11

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.



CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2011
NAME OF PROVIDER OR SUPPLIER Kaweah Delta Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 W. MINERAL KING, VISALIA, CA 93291 TULARE COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>Continued From page 7</p> <p>chest over the sternum) on Patient 1 and got no reaction. RRTL stated she had been on the floor with Patient 1 about 2 hours. During that time RRTL had not reviewed Patient 1's chart.</p> <p>On 5/5/11 at 12:20 p.m., during an interview, RN 1 stated during the trip to the CT, Patient 1 became less responsive and was no longer answering questions. RN 1 stated in her initial assessment she found Patient 1 did not have any facial drooping and her hand grips were found to be equal.</p> <p>On 5/10/11 at 11:55 a.m., during an interview, Physician 1 stated he left town on [redacted]/11 and handed over the care of Patient 1 to Physician 2 and the Trauma and Acute Care Surgical Services (TACSS) team. On [redacted]/11 he arrived at the hospital around 7:30 a.m. after having received a voice message from Physician 2. Physician 1 stated his assessment found Patient 1's tone symmetric and she had no facial droop. At this point Physician 1 requested a Finger Stick Blood Sugar (FSBS) to be done. The FSBS was found to be 20mg/dl (milligram per deciliter). Physician 1 stated the Patients blood glucose had been unstable post-op (after surgery) and a FSBS should have been done. Physician 1 requested a consultation from a neurological physician. Physician 1 stated he agreed with the Neurologists conclusion as to what caused Patient 1's coma.</p> <p>Patient 1's Neurological Consultation report dated [redacted]/11, by Physician 3, indicated "Clinical Impression: 1. Loss of consciousness and subsequent coma. This most likely occurred owing</p>		<p>procedure expectations for management of patients potentially experiencing hypoglycemia. On 7/25/11, a mandatory on-line "Glycemic Bundle" educational module for all appropriate KDMC nursing staff was initiated and will be completed by 8/12/11.</p> <p>i. Education Content included: A. Adult Parenteral Nutrition Policy (CP.01) revisions—which addressed changes to mirror those in "Adult Parenteral Nutrition Order Set" B. Sudden Discontinuation of TPN C. Planned Discontinuation of Parenteral Nutrition (TPN and PPN) D. Glucose Monitoring (Point of Care testing) E. Documentation of TPN Weaning and Discontinuation F. "Hypoglycemia, Adult" CP.62 policy G. "Hypoglycemia, Adult: Administration of Dextrose or Glucagon" Standardized Procedure</p> <p>ii. Persons Responsible: CNO for assuring all nursing services are provided in compliance with regulatory requirements. Clinical Directors, Nurse Managers, Clinical Educators, ensuring nursing staff are competent in understanding & complying with policies & procedures and monitoring is completed.</p> <p>iii. Monitoring process: Validation of Competency will be done by testing of 100% of KDMC nursing staff via HR On-line. Failure to complete educational module and successfully pass test by 8/15/11 will be managed individually by the respective nursing manager with progressive discipline if indicated i.e. suspension from work until completed.</p> <p>9) Consistent with KDMC's commitment to ensure patient safety and quality care, beginning 4/28/11 and completed by 5/12/11,</p>	<p>8/12/11</p> <p>8/15/11</p> <p>5/12/11</p>

Event ID:81GR11

7/21/2011

2:17:43PM

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

TITLE

(X6) DATE

Lindsay K Mann

CEO

8/15/11

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.

AUG 15 2011
DEPT OF HEALTH SERVICES
LICENSING & CERTIFICATION - FRESNO

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2011
NAME OF PROVIDER OR SUPPLIER Kaweah Delta Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 W. MINERAL KING, VISALIA, CA 93291 TULARE COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>Continued From page 8</p> <p>to hypoglycemia, which is analogous to hypoxemic insult to the brain. ...CT and MRI of the brain did not reveal any evidence of bleed or significant sized ischemic injury."</p> <p>On 5/10/11 at 12:59 p.m., during an interview, Physician 2 stated she received a phone call from RN 1 who stated Patient 1 was confused and had a change in LOC. Physician 2 then gave a telephone order for a head CT stat (now). Physician 2 stated she was aware of Patient 1's history of having a hemicolectomy and a Whipple procedure. Physician 2 stated because of the Whipple procedure Patient 1 was now a diabetic. Physician 2 went to the hospital and examined Patient 1. At this time Patient 1 was unresponsive. Patient 1 was exhibiting high blood pressure, a heart rate less than 60 and decerebrate posturing of the arms (a condition characterized by abnormal posturing of the limbs). Physician 2 called the family. Physician 2 stated at about 3:20 a.m., Patient 1's family was told Patient 1 was having a massive stroke. Physician 2 stated the family then made the decision to change the Patient 1's code status to DNR. When asked if she had read the CT scan report, Physician 2 stated she had and it indicated no evidence of ischemia.</p> <p>Patient 1's CT scan dated 4/18/11 at 3:05 a.m. indicated "No CT evidence for recent ischemia."</p> <p>Patient 1's magnetic resonance imaging (MRI) report dated [redacted]/11 at 4:02 p.m. indicated "No localized abnormalities are seen in the brainstem or cerebellum. No evidence of hemorrhage or</p>		<p>100% KDMC nursing staff were immediately re-educated via written materials and 1:1 stand-up in-service meetings on SBAR ("Situation-Background-Assessment-Recommendation") communication among health care team members, when a patient's condition changes:</p> <p>i. Persons Responsible: CNO for assuring all nursing services are provided in compliance with regulatory requirements. Clinical Directors, Nurse Managers, Clinical Educators ensuring nursing staff are competent in understanding & complying with policies & procedures and monitoring is completed.</p> <p>ii. Monitoring process: Ten (10) random nursing staff interviews regarding SBAR to be conducted on nursing units monthly, beginning 8/15/11. Results to be monitored by the PI Department and reported to MCRC and Patient Safety Committee for a minimum of 4 months to assure compliance. Opportunities for improvement identified will be managed individually by the respective Nurse Manager with progressive discipline if indicated.</p> <p>10) A Memo prepared by the Chief of Medical Staff was distributed to all Medical Staff on 4/29/11, reviewing SBAR communication among health care team members, when a patient's condition changes.</p> <p>i. Persons Responsible: MEC, PRC and Chief of Staff for oversight and ensuring proper adherence to Medical Staff bylaws, rules & regulations. Chief Medical Officer (CMO) for ensuring monitoring is completed.</p> <p>ii. Monitoring process: Ten (10) random medical staff interviews regarding SBAR to be conducted by the CMO monthly, beginning 8/16/11. Results to be monitored by the Medical Staff Office and PI Department and reported to MCRC and Patient Safety</p>	4/29/11

Event ID:81GR11

7/21/2011

2:17:43PM

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

TITLE

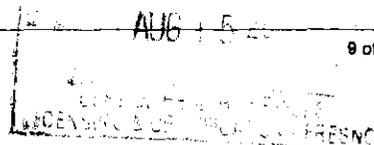
(X6) DATE

Lindsay K. Munn

CEO

8/15/11

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.



CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2011
NAME OF PROVIDER OR SUPPLIER Kaweah Delta Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 W. MINERAL KING, VISALIA, CA 93291 TULARE COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>Continued From page 10</p> <p>off correct information due to a wrong assessment, the RRTL failed to get sufficient Patient history for a proper assessment and there was no advocacy for the patient from the RRTL to activate the team and resulted in the death of the patient.</p> <p>These failures result in 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. [Type text]</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 1280.1(c).</p>		<p>B. Each KDMC acute care unit Nurse Manager will monitor at least 5 DNR charts per month to insure that care is provided in accordance with the DNR order. The audits will continue for a minimum of 4 months or until compliance is achieved and sustained for 4 consecutive months. Nurse Managers will review for non-compliance and follow up action as needed.</p> <p>12) Re-education was provided in the 8/11 issue (released 7/26/11) of the monthly physician newsletter distributed to all Medical Staff regarding the Medical Staff Rules and Regulations, specifically those indicated on Page 8, GENERAL CONDUCT OF CARE and when Consultation with a Member of the Consulting or Active Medical Staff is required.</p> <p>iii. Persons Responsible: Chief of Staff for ensuring proper reporting to Medical Executive Committee of Mortality Review Committee.</p> <p>iv. Monitoring process: 100% cases from Mortality Review Committee are reviewed to determine if the attending physician requested the necessary consultation. Mortality Review Committee (a subcommittee of MEC) meets monthly. Any failure to consult appropriately results in the care, clinical record and physician being referred for Peer Review. For Sentinel Events (SE) and Near-Misses, (NM) each case is evaluated by CRC to determine if case was SE or NM. Any case determined to require RCA, the need for consultation is part of the RCA analysis. The RCA process may recommend referral to Peer Review Committee (PRC) for failure to consult (along with there being additional criteria that may result in referral to PRC). Additional criteria include: appropriate admission location e.g. medical-surgical unit, assignment to appropriate specialty, appropriate history and physical documentation.</p>	August 2011

Event ID: 61GR11

7/21/2011

2:17:43PM

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

TITLE

(X6) DATE

Lindsay K. Munn

CEO

8/15/11

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2011
NAME OF PROVIDER OR SUPPLIER Kaweah Delta Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 W. MINERAL KING, VISALIA, CA 93291 TULARE COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>Continued From page 10</p> <p>off correct information due to a wrong assessment, the RRTL failed to get sufficient Patient history for a proper assessment and there was no advocacy for the patient from the RRTL to activate the team and resulted in the death of the patient.</p> <p>These failures result in 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. [Type text]</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 1280.1(c).</p>		, appropriate discharge summary documentation, appropriate management of care, identified systems issues and/or coding errors. Annually Mortality Review Committee formally reports to Medical Executive Committee.	

Event ID:81GR11

7/21/2011

2:17:43PM

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

Lindsay K. Mann

TITLE

CEO

(X6) DATE

8/15/11

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 required for continued program participation.

RECEIVED
AUG 18 2011