

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>050140</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/25/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>Kaiser Foundation Hospital Fontana</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>9961 Sierra Ave, Fontana, CA 92335-6720 SAN BERNARDINO COUNTY</b>		
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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: CA00398884 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 33090, 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 1280.1(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.</p> <p>1279.1 (c): (c) "The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made."</p> <p>The California Department of Public Health verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made.</p> <p>REGULATION VIOLATION Health and Safety Code Section 1280.1, California Code of Regulations, Title 22, section 70507 Nuclear Medicine General Requirements</p>		<p><b>Corrective Action:</b> Educational in-service conducted with all Nuclear Medicine staff on the requirement to remain with a patient while on Nuclear Medicine table until the patient is secured. In addition, staff counseled not to use the inflatable waffle mattress on the imaging tables.</p> <p>New safety straps ordered for all Nuclear Medicine tables.</p> <p>New safety straps (wraps) installed on all Nuclear Medicine tables.</p> <p>Educational in-service to Nuclear Medicine Staff on the use of new safety straps. Training included application of straps, in accordance with manufacturer's guidelines.</p> <p>Installed a closed circuit video system to better visualize the patient even when the technologist is in the room with the patient.</p> <p>Developed Diagnostic Imaging Patient Fall Prevention and Post Fall Procedures Policy.</p>	<p>5/13/14</p> <p>5/14/14</p> <p>5/22/14</p> <p>5/27/14</p> <p>6/9/14</p> <p>6/14/14</p>

Event ID:0ZUN11

9/3/2014

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

TITLE

(X6) DATE

*Nancy McMillan, RN*      *Director, Accreditation & Licensing*

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 7.

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.

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	<p>1280.1 (c): (c) For purposes of this section "immediate jeopardy" means a situation in which the licensee's non-compliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.</p> <p>AND</p> <p>70507 (a): (a)Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by administration and medical staff where such is appropriate.</p> <p>Based on interview and document review the facility failed to ensure the safety of Patient A, when the patient was left unsupervised, on the MUGA (Multi Gated Acquisition Scan, a nuclear medicine test to evaluate the function of the heart) table. After the scan was completed, Patient A fell off the table in the Radiology Department. This failure resulted in Patient A suffering a subarachnoid hemorrhage (bleeding in the brain) and subsequent death.</p> <p>FINDINGS: On May 19, 2014 at 12:50 PM, entered the facility unannounced to investigate the incident. During clinical record review on May 19, 2014, it was noted that Patient A was admitted from the facility's Emergency Department to a Medical/Surgical Unit, on May 5, 2014 at 2:05 PM, with diagnosis that</p>		<p><b><u>Corrective Action: (Continued from previous page)</u></b></p> <p>Fall prevention principles and protocols reinforced through Diagnostic Imaging Newsletter sent to all staff.</p> <p>Conducted fall prevention training as part of annual staff training during the month of July (5 sessions) which included providing a copy of new Diagnostic Imaging Patient Fall Prevention and Post Fall Procedure policy.</p> <p><b><u>Responsible Party:</u></b> Director Radiology (Diagnostic Imaging) Chief of Radiology</p> <p><b><u>Monitoring Process:</u></b> A total of fifty random visual observation audits will be conducted monthly in Nuclear Medicine to ensure that safety straps are being used and properly applied. Audit results will be reported to Patient Safety Leadership Committee monthly until 100% compliance has been reached for four consecutive months.</p>	<p>6/23/14</p> <p>7/29/14</p>

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	<p>included large B cell lymphoma (cancerous tumor), diffuse edema (swelling) to the abdomen and lower extremities, and inability to ambulate with worsening lethargy and weakness.</p> <p>On May 19, 2014, clinical record review was conducted of Patient A's "Schmid Fall Risk" (an assessment of the patient to determine fall risk), dated May 5, 2014. Patient A's score was (3), which indicated that the patient was at risk for falls. A yellow fall risk band was applied to Patient A's wrist by facility staff to warn other staff that Patient A was a fall risk.</p> <p>On May 19, 2014 a review of the Oncology note, dated May 8, 2014, indicated the following "...discussed management with family. Will need chemotherapy with RCHOP (a combination of chemotherapy drugs)?will need MUGA? Confusion waxing and waning (patients' orientation to time and place not consistent)".</p> <p>During record review on May 19, 2014, it was noted that on May 8, 2014 at 3:00 PM, Patient A was transferred to Nuclear Medicine for a MUGA scan and arrived via gurney with a waffle mattress beneath her. Patient A was transferred onto the MUGA table with the waffle mattress remaining beneath her.</p> <p>During an interview with the radiology technician (RT 1) on May 23, 2014, at 10:30 AM, RT 1 advised that he, "...moved Patient A using the waffle pad onto the table. RT 1 also advised he brought the waffle pad sides together and used tape to secure</p>			

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	<p>the pad at Patient A's feet, knees and hips. RT 1 also explained that because IV (vein) access was needed for Patient A throughout the procedure, he made a virtual sling with a sheet for placement of Patient A's right forearm. RT 1 also advised that neither he nor the facility staff used a safety belt to secure Patient A on the MUGA scan table.</p> <p>On July 24, 2014 at 12:30 PM, during telephone interview with the Director of Accreditation and Licensing (DA&amp;L), asked if prior to Patient A's fall was there a policy and procedure at the facility regarding use of a safety belt for patients while on the MUGA scan table. DA&amp;L responded that she verified with Nuclear Medicine and Radiology departments, that there was no policy and procedure in place for use of a safety belt while a patient is on the MUGA scan table.</p> <p>On July 24, 2014 at 12:30 PM, telephone interview with (DA&amp;L) asked if on the date of Patient A's fall was there a practice to swaddle patients when on the MUGA scan table. DA&amp;L stated, "no, it was not a practice to swaddle patients while/during procedures on the MUGA scan table".</p> <p>During the interview with RT 1 on May 23, 2014 at 10:30 AM, RT 1 advised that "at approximately 4:00 PM on May 8, 2014, it was necessary for RT 1 to go from the Imaging room to the work station across the hall, (a distance of approximately twelve (12) feet with no visual field for observation of Patient A) and get the paper report." Patient A was left alone for 30-40 seconds. RT 1 then stated he "heard the waffle mattress sliding and returned to</p>				

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	<p>the imaging room." RT 1 stated, "I found the patient (Patient A) with the left side of her face on the ground, with her arms out to either side of her face; stomach and torso against the camera, still on the scanning table, with legs up in the air, nose bleeding with the fall. I asked her if she could breathe she said 'yes,' then her breathing got heavier. Within seconds I yelled code (notifying staff that the patient is in severe respiratory and/or cardiac distress)."</p> <p>Review of Patient A's Resuscitation Record (a note on the care and medications administered during the code) indicated that the code blue was called at 4:00 PM on May 8, 2014 and Patient A was intubated (tube inserted into airway). Following intubation, Patient A had a stat (immediate) CT (imaging scan) of the brain at 4:53 PM. The CT showed a subarachnoid hemorrhage and Patient A was transferred to Intensive Care Unit (ICU), on a ventilator (breathing machine).</p> <p>During a clinical record review of Patient A's progress note, it indicated that on May 8, 2014, Patient A's daughter was informed that the patient fell off the scan table and was transferred to ICU.</p> <p>During clinical record review, Patient A's Critical Care Progress Note dated May 9, 2014 indicated: "repeat CT of the brain this AM shows interval increase in SAH (sub arachnoid hemorrhage)." The Critical Care Progress note dated May 10, 2014 indicated: "Patient A is on vent (ventilator/breathing machine), more restless this AM." Further, the Critical Care Progress note</p>				

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	<p>dated May 11, 2014 indicated that Patient A had "worsening renal (kidney) function." Patient A's Critical Care progress note of May 12, 2014 indicated: "no improvement. Renal function continues to deteriorate. Family decided to withdraw care today. Code status was changed to DNR (do not resuscitate). Patient will be extubated (airway tube removed) and placed on comfort care only, per family decision." Patient was subsequently extubated (taken off life support).</p> <p>A review of Patient A's "Critical Care Follow Up" note, dated May 12, 2014, indicated that Patient A was pronounced dead on May 12, 2014 at 4:51 PM.</p> <p>On August 19, 2014, a review was conducted of the autopsy report from the San Bernardino County Sheriff's Department Coroner Division, Coroner's case number: 701403702, for Patient A. The autopsy report's completion date was May 16, 2014. The report's findings were the following: "Diagnosis: I. Blunt force injury of the head (traumatic blow/injury to the head). F. Diffuse subarachnoid hemorrhage of the cerebrum (bleeding in the front part of the brain) and cerebellum (part of the brain located directly behind the cerebrum)." The cause of death was set forth as follows: "Cause of Death: Blunt force injury of the head."</p> <p>The 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</p>				

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	<p>meaning of Health and Safety code Section 1280.1 (c).</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>				

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