

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050709	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2011
NAME OF PROVIDER OR SUPPLIER Desert Valley Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 16850 Bear Valley Rd, Victorville, CA 92395-5794 SAN BERNARDINO COUNTY		
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	<p>1280.1(a)(c)(d):</p> <p>(a) Subject to subdivision (d), prior to the effective date of regulations adopted to implement Section 1280.3, if a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars (\$25,000) per violation.</p> <p>(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>(d) This section shall apply only to incidents occurring on or after January 1, 2007. With respect to incidents occurring on or after January 1, 2009, the amount of the administrative penalties assessed under subdivision (a) shall be up to one hundred thousand dollars (\$100,000) per violation. With respect to incidents occurring on or after January 1, 2009, the amount of the administrative penalties assessed under subdivision (a) shall be up to fifty thousand dollars (\$50,000) for the first administrative penalty, up to seventy-five thousand dollars (\$75,000) for the second subsequent administrative penalty, and up to one hundred thousand dollars (\$100,000) for the third and every subsequent violation.</p> <p>AND</p>			

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	<p>70223 (b)(2):</p> <p>(b) A committee of the medical staff shall be assigned responsibility for:</p> <p>(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.</p> <p>The above regulation was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to implement the policy and procedure for time out prior to a surgical procedure. On 6/15/11 (June 15, 2011) (time not documented), Patient 1 underwent a right chest tube placement in error. Specifically, Patient 1 was diagnosed with a left rib fracture that necessitated the need to place a left chest tube. However, the tube was placed on Patient 1's right side. After the error was identified, a left chest tube was placed in Patient 1 on 6/15/11 (June 15, 2011) (no time documented). Patient 1 had both chest tubes (right and left) in place for 24 hours.</p> <p>FINDINGS:</p> <p>The clinical record for Patient 1 was reviewed on 2/20/12 (February 20, 2012), at 9:30 AM. Patient 1 was transferred to Hospital A at 11:18 AM on June 15, 2011. The Triage assessment documentation included the following, "Patient sent over from</p>			

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	<p>prison for shortness of breath s/p (status post) jail fight last week, increased shortness of breath and possible pneumonia c/o (complained of) increased nausea vomiting and seizure activity. Diminished lung sounds to lower left."</p> <p>An untitled document, dated 6/15/11, was provided to the Department from Hospital A. The following was noted, "The patient is a [REDACTED] gentleman who comes to the emergency department again because of left sided chest pain. Apparently, he was in the emergency room recently on 6/5/11 for left chest pain, status post assault in the prison. He was found to have left tenth-rib fracture. He was treated and sent back to the prison. Apparently he came back today with more pain and apparently some fluid collection was noticed. The patient underwent chest tube placement first on the right then on the left and 2000 ml of blood came out from the left plural space."</p> <p>The untitled document dated 6/15/11 further indicated that a CT chest without contrast and with coronal reconstruction images" was ordered by Medical Doctor (MD) B, at 12:43 pm on 6/15/11, and dictated the same day at 14:01 (2:01 pm). The document noted the following: CT of the chest shows partial atelectasis (the collapse or closure of alveoli resulting in reduced or absent gas exchange) of left upper lobe and left lower lobe. A large pleural effusion (excess fluid that accumulates between the two pleural layers, the fluid-filled space that surrounds the lungs) is identified."</p>		<p>The hospital would like to clarify that the "untitled document" is the patient's History and Physical Report completed by the admitting physician.</p> <p>The hospital would like to clarify that the "untitled document" is the CT report completed by the Radiologist.</p>		

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	<p>During an interview with the Emergency Department (ED) Manager on 2/20/12 (February 20, 2012), she stated, "Only a couple of minutes after it was dictated, he [MD B] would have been able to pull the CT up from the computer. He did not wait for the CT before he did the procedure (the right chest tube placement)."</p> <p>A second document entitled "AUTHORIZATION FOR AND CONSENT TO SURGERY OR SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURES" was signed by MD B at 6 PM on 6/15/11. The consent form was signed by the patient on 6/16/11 at 5 PM and noted that the patient was acknowledging consent for the placement of "chest tube placement - bilateral." The form was witnessed by the registered nurse (RN 1).</p> <p>During an interview with Emergency Room Director on 10/23/14 (October 23, 2014 at 12PM, she stated that there was no written consent for the initial placement of the right chest tube, as the patient was shackled and could not easily sign. She stated that consent was provided by the patient verbally, however, there was no documentation to note this in the clinical record. The Emergency Room Director further stated that the patient was unshackled in order to sign the consent for the placement of the second chest tube that was placed on the left side.</p> <p>During further interview with the Emergency Room Director on 10/23/14 (October 23, 2014), she stated that the written consent obtained for "chest tube placement - bilateral" was because a written</p>		<p>The hospital would like to clarify that the date the patient signed the consent was 06/15/11 not 06/16/11. 06/16/11 was written in error by the primary nurse. The correct date is documented in the nursing notes. This was validated with the nurse at the time of the investigation. Education was provided to the nurse regarding patient consent forms are to be completed as accurately as possible.</p> <p>The hospital would like to clarify that the Emergency Department Physician documented in the medical record that he obtained the consent and explained the risks and benefits of the procedure to the patient, prior to the initial procedure.</p>	06/17/11	

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	<p>consent had not been obtained at the time of the first chest tube placement so that this consent would cover both the right and left side placements of the chest tubes.</p> <p>During an interview with MD B on 2/22/12 (February 22, 2012) at 11:20 AM, when asked why the chest tube was placed on the right side rather than the left side, he stated, "I just flipped the X-ray and looked at it as right. I glanced at the x-ray and then inserted the tube. The x-ray came with the patient. I don't recall ordering a CT scan. I saw right instead of left."</p> <p>Hospital A's Departmental Policy and Procedure entitled, "Surgical Site- Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Procedure," revised 2/09, was reviewed on 6/28/11 (June 28, 2011). The policy and procedure sets forth the following purpose: "[Hospital A] shall provide consistency and assure that all patients admitted for surgery shall have the surgical site identified properly." The policy also sets forth its procedures and implementation of protocol, with relevant provisions set forth below.</p> <p>1. Pre-Operative Verification process</p> <p>1.1. Purpose</p> <p>1.1.1. To ensure that all of the relevant documents and studies are available prior to the start of the procedure and that they have been reviewed and are consistent with each other and with the patient's expectations and with the teams understanding of the intended patient, must be</p>		<p>The Physician Peer Review Committee conducted a review of this case and the case was also reviewed and discussed by the Medical Executive Committee and the Governing Board, and appropriate action was taken.</p> <p>The Emergency Department Medical Director also advised the Emergency Department physicians via written memo to repeat all x-rays, labs, and other tests from outside facilities.</p> <p>Attachment 1</p>	<p>09/29/11</p> <p>06/17/11</p>	

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	<p>addressed before starting the procedure.</p> <p>1.2 Process</p> <p>1.2.1 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-operative preparation of the patient, up to and including the "time out" just before the start of the procedure.</p> <p>2. Marking the Operative Site</p> <p>2.1. Purpose</p> <p>2.1.1. To identify unambiguously the intended site of incision or insertion.</p> <p>2.2 Process</p> <p>2.2.1. For procedures involving right/left distinction, multiple structures (such as fingers and toes) or multiple levels (as in spinal procedures), the intended site should be marked such that the mark will be visible after the patient has been prepped and draped.</p> <p>3. "Time Out" immediately before starting the procedure.</p> <p>3.1. Purpose</p> <p>3.1.1. To conduct a final verification of the correct patient, procedure, site and as applicable, implants.</p> <p>3.1.2. Active communication among all members of the surgical/procedure team, consistently initiated by a designated member of</p>				

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	<p>the team, conducted in a "fail-safe" mode, i.e., the procedure is not started until any questions or concerns are resolved.</p> <p>Implementation of Protocol</p> <p>1. Pre-Operative verification Process</p> <p>1.2. Verification of the correct person, procedure, and site shall occur (as applicable):</p> <p>1.1.1 At the time of the surgery/procedure is scheduled.</p> <p>1.1.2. At the time of admission or entry in to the facility.</p> <p>1.1.4 With the patient involved, awake and aware, if possible.</p> <p>During an interview with the ED Director on 10/23/14 (October 23,2014), when asked if the placement of the chest tube for Patient A was considered an emergency, she stated that there was no documentation to show that the physician had considered it an emergency.</p> <p>During an interview with the ED Manager on 2/20/12 (February 20, 2012), she reviewed the clinical record and was unable to provide documentation to show that the policy and procedures for wrong site surgery had been implemented, as written, or that staff members had followed the policy and procedures for wrong site surgery in relation to the chest tube placement for Patient 1. Further, the ED Manager was unable to provide documentation that the procedure for Patient 1 was done as an emergency.</p>		<p>After investigation and knowledge of the chest tube placed on the incorrect side, the following process improvements were implemented: The Emergency Department staff were in-serviced regarding the Surgical Site Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Procedure policy.</p> <p>Attachment 2 A Bedside Procedure Assessment was created in the electronic medical record.</p> <p>Attachment 3 The nurse was verbally counseled after the investigation.</p> <p>In 2011 a sampling of emergency department medical records were reviewed to monitor the compliance with the Surgical Site Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Procedure policy. For medical records that were found to be deficient, the Emergency Department Nursing Director verbally followed up with the staff and provided education.</p> <p>Responsible Parties: Emergency Department Nursing Director Emergency Department Medical Director</p> <p>The Emergency Department Nursing Director recalls during the initial investigation in 2011 that MD B discussed that the procedure was deemed emergent at the time the initial chest tube was placed.</p>	<p>06/23/11 02/24/12 03/29/12 04/26/12 06/21/12</p> <p>03/15/12</p> <p>06/17/11</p>	

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	<p>The facility's failure to follow its policy and procedure for wrong site surgery caused unnecessary pain and discomfort, as well as the risk of bleeding, infection and lung damage to Patient 1. This action is 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 (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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