



MARK B HORTON, MD, MSPH
Director

State of California—Health and Human Services Agency
California Department of Public Health



ARNOLD SCHWARZENEGGER
Governor

MAY 11 2010

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
ARTICLE NO. 7004 0750 0000 6845 7177

Southwest Healthcare Systems
25500 Medical Center Drive
Murrieta, California 92562

**Re: Universal Health Services of Rancho Springs, Inc., dba Southwest
Healthcare System-Murrieta, CA
CDPH Case No. PCR-10-0019**

Dear Ken Rivers:

As indicated in our letter dated April 19, 2010, the California Department of Public Health is very concerned about recent surveys involving patient care violations at Universal Health Services of Rancho Springs (Southwest Health Car Systems).

Consistent with our letter, we are forwarding the formal Accusation to initiate the process for license revocation action involving your facilities. Enclosed, please find:

Statement to Respondent (original)
Accusation (copy)
Notice of Defense (two blank forms)
Government Code sections 11507.5, 11507.6, and 11507.7 (copy).

Sincerely,

Belinda B. Whitsett
Assistant Chief Counsel

Cindy E. Lloyd
Sr. Staff Counsel

Enclosures

cc: See Next Page.

cc: Lorraine Sosa, District Administrator
Riverside District Office
Licensing and Certification
Department of Public Health
625 Carnegie Dr., Suite 280
San Bernardino, CA 92408

Mary Jolls, Chief
Field Operations Branch, Region I
Licensing and Certification Program
Department of Public Health
P.O. Box 997377
Sacramento, CA 95899-7377

BEFORE THE
DEPARTMENT OF HEALTH CARE SERVICES
OFFICE OF ADMINISTRATIVE HEARINGS AND APPEALS

In the Matter of the Accusation Against:

SOUTHWEST HEALTHCARE SYSTEM

25500 Medical Center Dr.
Murrieta, CA 92562

License No.: 25000262

Respondent.

) CDPH Case No. PCR-10-0019

) STATEMENT TO RESPONDENT

TO THE RESPONDENT:

The enclosed Accusation in this matter is hereby served on you.

All communications pertaining to this matter, including the notices and requests referred to below, should be sent to the attorney who represents the Department of Public Health (agency).

Unless a written request for a hearing signed by or on behalf of the person named as respondent in the accompanying Accusation is delivered or mailed to the agency within 15 days after the Accusation was personally served on you or mailed to you, the agency may proceed upon the Accusation without a hearing. The request for a hearing may be made by delivering or mailing the enclosed form entitled Notice of Defense, or by delivering or mailing a notice of defense as provided by section 11506 of the Government Code to:

Cindy E. Lloyd
Staff Counsel
Office of Legal Services
Department of Public Health
MS 0506
P.O. Box 997377
Sacramento, California 95899-7377

If you use the enclosed form Notice of Defense as your request for a hearing, it will be deemed a specific denial of all parts of the Accusation not expressly admitted. However, you cannot use this form to present any of the other defenses or objections permitted by Government Code section 11506. Other defenses or objections permitted by Government Code section 11506 must be raised in specific conformance with the language of section 11506.

If you desire the names and addresses of witnesses or an opportunity to inspect and copy the items mentioned in section 11507.6 of the Government Code in the possession, custody or control of the agency, you may contact the agency's attorney identified above.

Copies of Government Code sections 11507.5, 11507.6, and 11507.7 are enclosed.

The procedures which govern this hearing process are contained in Health and Safety Code, section 1428, and to the extent it is not inconsistent with this section, the California Administrative Procedure Act chapters 4.5 and 5 (commencing with section 11400) of part 1 of division 3 of title 2 of the Government Code. If you would like a copy of these governing procedures, you may contact the agency's attorney identified above.

The hearing may be postponed for good cause. If you have good cause, you are obliged to notify the agency or, if an Administrative Law Judge has been assigned to the hearing, the Office of Administrative Hearings and Appeals, Department of Health Care Services at 1029 J Street, Suite 200, MS 0017, Sacramento, CA 95814, within 10 working days after you discover the good cause. Failure to notify the agency or judge within 10 working days will deprive you of a postponement.

1 BELINDA WHITSETT
Assistant Chief Counsel
2 CINDY E. LLOYD
Senior Staff Counsel
3 Office of Legal Services-Administrative Litigation
P.O. Box 997377, MS 0506
4 Sacramento, California 95899-7377
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5 Attorneys for the State
6 Department of Public Health
Licensing and Certification Division
7

8 BEFORE THE
9 STATE DEPARTMENT OF HEALTH CARE SERVICES
OFFICE OF ADMINISTRATIVE HEARINGS AND APPEALS

10
11 In the Matter of the Accusation Against:) DPH Case No. PDR-10-0019
12 SOUTHWEST HEALTHCARE SYSTEM) **ACCUSATION**
13 25500 Medical Center Drive)
Murrieta, California 92562)
14)
15 Hospital License Number: 250000262)
Respondents)
16)
17)

18 I.

19 KATHLEEN BILLINGSLEY, Complainant herein (Complainant), files this
20 Accusation in her official capacity as the duly appointed Deputy Director, Center for
21 Healthcare Quality, Licensing and Certification, Department of Public Health, State of
22 California.

23 II.

24 **JURISDICTION**

25 THE DEPARTMENT OF PUBLIC HEALTH (Department) is the agency
26 of the State of California responsible for licensing of General Acute Care Hospitals
27 pursuant to California Health and Safety Code section 1250 et seq. and California Code

1 of Regulations, title 22, section 70001 et seq.

2 SOUTHWEST HEALTHCARE SYSTEM (Respondent), is licensed by the
3 Department to operate and maintain two General Acute Care Hospitals: Rancho Springs
4 Medical Center, located at 2550 Medical Center Drive in Murrieta, California (RSMC) and
5 Inland Valley Medical Center (IVMC), located at 36485 Inland Valley Drive, Wildomar,
6 California under License No. 250000262. The hospitals are located within five miles of
7 each other in Riverside County.

8 Pursuant to said license, Respondent is required to comply with Health and
9 Safety Code section 1250, et seq., and California Code of Regulations, title 22, section
10 70001, et seq.

11 Respondents' license to operate and maintain the hospitals is current, and
12 will expire on November 6, 2010. Respondents' license is attached as Exhibit A hereto.

13 III.

14 BACKGROUND

15 Respondent operates two Riverside County hospitals under one
16 consolidated license for a total bed capacity of 218. There are 96 beds at Rancho
17 Springs Medical Center in Murrieta, and 122 beds at Inland Valley Medical Center in
18 Wildomar.

19 The two hospitals provide between them the following on site services:
20 general acute care, perinatal services, intensive care, basic emergency care, cardiac
21 catheter lab services, nuclear medicine, physical therapy, occupational therapy,
22 respiratory care, social services, and mobile magnetic resonance imaging.¹

23 Over the past 30 months, numerous meetings between Respondent,
24 the Department, and the Centers for Medicaid Services (CMS) have occurred to

25
26 ¹ All of these services are available at other hospitals within 25 miles of Respondent hospitals.
27

1 emphasize the seriousness and significance of the provider's continued non-compliance
2 with licensing statutes and regulations.

3 **IV.**

4 **HOSPITAL LICENSE SUSPENSION AND REVOCATION**

5 Health and Safety Code section 1294 provides that the Department may
6 revoke the license of a general acute care hospital for violation of any of the provisions of
7 chapter 2, division 2, of the Health and Safety Code, or of the rules and regulations
8 promulgated thereunder; or for conduct inimical to the public health, morals, welfare, or
9 safety of the people of the State of California in the maintenance and operation of a
10 general acute care hospital.

11 Good cause exists for the revocation of Respondent's license, pursuant to
12 Health and Safety Code section 1294, in that Respondent has violated, and permitted
13 the violation of State statutes and regulations governing the operation of general acute
14 care hospitals, and has engaged in conduct inimical to the public health, welfare, or
15 safety of the people of the State of California.

16 Wherever it is alleged in this Accusation that Respondent violated one or
17 more statutes or regulations, the allegation shall be deemed in each case to mean that
18 Respondent, through its employees or agents, violated the statute or regulation and that
19 Respondent aided, abetted, or permitted the violation.

20 **V.**

21 **VIOLATIONS**

22 Respondent has failed to comply with numerous licensure requirements as
23 specified below which demonstrate throughout a three year period a pattern and practice
24 of inability to comply with state requirements for ensuring the welfare and safety of
25 patients in Respondent facilities. Each action by Respondent individually constitutes
26 grounds for revocation of the facility license. Each action also constitutes conduct
27 inimical to the public health, morals, welfare, or safety of the people of the State of

1 California in the maintenance and operation of the premises or services for which the
2 license is issued.

3 **VI.**

4 **RESPONDENT PLACED CRITICALLY ILL PATIENTS IN AREAS**
5 **NOT DESIGNATED FOR INTENSIVE CARE TREATMENT**

6 In the survey conducted on October 4, 2007 it was determined that critically
7 ill patients were assigned to rooms not equipped to care for such patients. At the time of
8 the October 4th survey, three patients were housed in this unauthorized location.

9 Patient 914 was a multiple trauma secondary to a motor vehicle accident.
10 According to RN 1, patient 914 had a respiratory arrest prior to a previously planned
11 surgery, came to the ICU satellite on a ventilator, was weaned off the ventilator, and was
12 waiting to go back to surgery. Neither critical care medications, nor continuous central
13 monitoring of cardiac rhythm, blood pressure or oxygen levels was available at this
14 unauthorized location.

15 Patient 915 was admitted with a vertebral artery dissection, was in a very
16 fragile neurological state, and needed to have the door closed and the lights off. RN 1
17 stated that when the door was closed, she could not see the patient or the cardiac
18 monitor.

19 Patient 916 was admitted for treatment of a gastrointestinal bleed and had
20 received five units of blood. Neither critical care medications, nor continuous central
21 monitoring of cardiac rhythm, blood pressure or oxygen levels was available at this
22 unauthorized location.

23 This conduct by Respondent constitutes conduct inimical to the public
24 health, morals, welfare, or safety of the people of the State of California in the
25 maintenance and operation of the premises or services for which the license is issued.
26 This conduct is also a violation of title 22 CCR section 70805.

27 ///

1 Pursuant to section 70805, Respondent was required to obtain written
2 approval from the Department before it converted medical beds to ICU beds. The intent
3 of this regulation is to ensure that the facility has complied with all state and federal laws
4 necessary to protect the patients and staff.

5 **VII.**

6 **RESPONDENT PLACED CRITICALLY ILL PATIENTS IN**
7 **AREAS THAT DO NOT POSSESS ICU TRAINED NURSES,**
8 **CRITICAL CARE MEDICATIONS OR EQUIPMENT**

9 Respondent staff (RNs assigned to the ICU satellite patients) stated some
10 of the critical care medications and equipment used in the ICU were not available on 2
11 East. Specifically, on June 6, 2008 at 9:05 am, an ICU nurse told Department staff that
12 if she had an ICU emergency, the medications and supplies in the satellite ICU unit were
13 different than the medication and supplies in ICU, and the nurses were not ICU trained,
14 so she would call for the ICU charge nurse and "hope she was available."

15 A review of facility staffing records revealed that the ICU satellite unit was
16 frequently staffed with only one registered nurse, which supported the ICU nurse's
17 concern of walking away from her patients to get medications and supplies because
18 "nobody" was there to watch her patients like they were in the ICU.

19 This conduct constitutes conduct inimical to the public health, morals,
20 welfare, or safety of the people of the State of California in the maintenance and
21 operation of the premises or services for which the license is issued. This conduct is
22 also a violation of title 22 CCR 70495(d) and section 70211. Section 70495 provides as
23 follows:

24 "There shall be not less than two nursing personnel
25 physically present in the intensive care unit when a patient is
26 present. At least one of the nursing personnel shall be a
27 registered nurse."

Pursuant to section 70211:

"(a)The nursing service shall be organized, staffed,
equipped, and supplied, including furnishings and resource
materials, to meet the needs of patients and the service."

1 VIII.

2 **RESPONDENT CONTINUES TO PLACE PATIENTS IN**
3 **JEOPARDY BY UNLAWFULLY PLACING THEM IN AREAS NOT**
4 **EQUIPPED TO PROVIDE PROPER CARE**

5 During an unannounced visit to the IVMC campus on April 16, 2008, the practice
6 of admitting ICU patients to general acute care beds for ICU care was again identified.
7 The Chief Nursing Officer and Director of ICU/ED were immediately notified of the
8 unlawful actions in converting general acute care beds to ICU beds.

9 During an unannounced visit to the IVMC campus on June 6, 2008, the practice of
10 admitting ICU patients to general acute care beds for ICU care was identified AGAIN. A
11 written cease and desist was immediately issued due to the facility's repeated failure to
12 stop conversion of general acute care beds to ICU beds. (Exhibit B)

13 During a tour of the medical surgical floor at the IVMC campus on July 15, 2008,
14 at 4:15 p.m., the floor was observed to have one nursing station in the front of each wing,
15 with long hallways that led to individual patient rooms. There was one medication room
16 located on each wing, a supply room, and a dirty utility room. With the physical layout of
17 the floor, a nurse caring for an ICU patient would have to travel down the hall for
18 medications, supplies, assistance with order entry into the computer, and to find help,
19 leaving the patient unattended and at risk for decompensation without immediate
20 recognition.

21 This conduct constitutes conduct inimical to the public health, morals, welfare, or
22 safety of the people of the State of California in the maintenance and operation of the
23 premises or services for which the license is issued and is also a violation of title 22 CCR
24 70499 which provides as follows:

25 "(a)(5) All [ICU] beds shall be placed in relation to the
26 nurses' station or work area to obtain maximum observation
27 of patients. "

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IX.

EVEN AFTER MULTIPLE WARNINGS OF POTENTIAL ADVERSE CONSEQUENCES TO PATIENTS, INCLUDING A CEASE AND DESIST ORDER, RESPONDENT CONTINUED TO MOVE PATIENTS TO AREAS NOT EQUIPED TO PROPERLY CARE FOR THEM

A record review for Patient 217, conducted on July 15, 2008 at IVMC revealed that Patient 217, a 73 year old female, was admitted to the ICU facility on July 4, 2008, with diagnoses that included respiratory failure. The patient was on a ventilator when admitted to the ICU. On July 11, 2008, the patient was weaned off the ventilator, and placed on a BiPAP machine (positive pressure machine to aid in effective breathing, requiring close and intensive monitoring). Patient 217 was transferred to the medical surgical floor, (still requiring ICU care and a BiPAP machine) solely for the purpose of accommodating a neurosurgical patient.

A record review on July 16, 2008 for Patient 111 revealed that Patient 111, a 70 year old female, was admitted to the facility pre-operative unit on June 23, 2008, for an elective spinal fusion. The post operative orders stated that the patient was to be admitted to ICU. The ICU census sheets were reviewed on July 16, 2008. The sheet, dated June 23, 2008, indicated the ICU beds were full, and there was an additional ICU patient on the medical surgical floor waiting for an ICU bed when Patient 111 was taken to surgery. The census sheets further indicated Patient 111 stayed in the PACU, requiring ICU care, for two days before being transferred to an ICU bed.

A record review on July 16, 2008 for Patient 112 revealed that Patient 112, a 71 year old male, was admitted to the facility pre-operative unit on June 24, 2008, for an elective spinal fusion. The post-operative orders stated that the patient was to be admitted to ICU. The ICU census sheets were reviewed on July 16, 2008. The sheet, dated June 24, 2008, indicated the ICU beds were full, with one patient on the medical surgical unit waiting for an ICU bed, and one patient in the PACU waiting for an ICU bed when Patient 112 was taken to surgery. The census sheets further indicated Patient 112

1 stayed in the PACU for 1.5 days requiring ICU care. Records indicated Patient 112 was
2 never admitted into an ICU bed during the patient's length of stay.

3 A record review on July 16, 2008 for Patient 204 revealed that Patient 204,
4 an 82 year old female, was admitted to the facility pre-operative unit on June 9, 2008 for
5 an elective carotid endarterectomy (opening the carotid artery to remove plaque). The
6 post operative orders stated that the patient was to be admitted to the ICU. The ICU
7 census sheets were reviewed on July 16, 2008. The sheet, dated June 9, 2008,
8 indicated the ICU beds were full, with three patients in the ED waiting for ICU beds, and
9 two patients in the PACU waiting for ICU beds when Patient 204 was taken to surgery.
10 The census sheets further indicated Patient 204 stayed in the PACU for 1.5 days
11 requiring ICU care, and was transferred to the medical surgical unit. Patient 204 was not
12 admitted to an ICU bed during the patient's entire length of stay.

13 A record review on July 16, 2008 for Patient 205 revealed that Patient 205,
14 a 66 year old female, was admitted to the facility pre-operative unit on June 9, 2008, for
15 an elective carotid endarterectomy (opening the carotid artery to remove plaque). The
16 post operative orders stated that the patient was to be admitted to the ICU. The ICU
17 census sheets were reviewed on July 16, 2008. The sheet, dated June 9, 2008,
18 indicated the ICU beds were full, with three patients in the ED waiting for ICU beds, and
19 three patients in the PACU waiting for ICU beds when Patient 205 was taken to surgery.
20 The census sheets further indicated Patient 205 stayed in the PACU for 24 hours
21 requiring ICU care, and was discharged home from the PACU. Patient 205 was not
22 admitted to an ICU bed during the patient's entire length of stay.

23 A record review on July 16, 2008 for Patient 206 revealed that Patient 206,
24 a 72 year old male, was admitted to the facility pre-operative unit on June 16, 2008, for
25 an elective abdominal aneurysm (a weakness in the wall of the artery) repair. The post
26 operative orders stated that the patient was to be admitted to the ICU. The ICU census
27 sheets were reviewed on July 16, 2008. The sheet, dated June 16, 2008, indicated the

1 ICU beds were full when Patient 206 was taken to surgery. The census sheets further
2 indicated Patient 206 stayed in the PACU for 24 hours requiring ICU care, and was
3 discharged home from the PACU. Patient 206 was not admitted to an ICU bed during the
4 patient's entire length of stay.

5 A record review on July 16, 2008 for Patient 207 revealed that Patient 207,
6 a 62 year old female, was admitted to the facility pre-operative unit on June 16, 2008, for
7 an elective spinal fusion. The post operative orders stated that the patient was to be
8 admitted to the ICU. The ICU census sheets were reviewed on July 16, 2008. The
9 sheet, dated June 16, 2008, indicated the ICU beds were full when Patient 207 was
10 taken to surgery. The census sheets further indicated Patient 207 stayed in the PACU
11 for 24 hours requiring ICU care, and was transferred to the medical surgical unit. Patient
12 207 was not admitted to an ICU bed during the patient's entire length of stay.

13 A record review on July 16, 2008 for Patient 226 revealed that Patient 226,
14 a 69 year old female, was admitted to the facility pre-operative unit on June 18, 2008 for
15 an elective carotid endarterectomy. The Short Stay History and Physical dated June 18,
16 2008 at 10 a.m., indicated Patient 226 was admitted with a chief complaint of "TIA
17 (Transient Ischemic Attack) April 2008 Slurred speech." The plan of care indicated the
18 patient was to undergo "L CEA," (Left Carotid endarterectomy). Carotid endarterectomy
19 is a surgical procedure in which plaque is removed from a carotid artery. Post surgical
20 risks include neurological complications, secondary to stroke and potentially life-
21 threatening swelling of the neck due to hemorrhage. The patient's pre-operative
22 assessment indicated the patient was brought to the facility by a spouse at 8 a.m. on
23 June 18, 2008. The operative report indicated the patient underwent carotid
24 endarterectomy, with patch angioplasty on June 18, 2008. The post operative orders
25 stated that the patient was to be admitted to the ICU. The operative report indicated
26 Patient 226's disposition was the recovery room, then ICU. On June 18, 2008, at 1:45
27 p.m., it was documented in the nurse's notes the patient was "ICU hold in PACU."

1 On July 16, 2008, the Critical Care Unit (ICU) census report for June 18,
2 2008, was reviewed. The report indicated the facility had eight patients in the Intensive
3 Care Unit and an additional four patients in the emergency room waiting for ICU beds,
4 when Patient 226 was admitted for surgery. The census sheets further indicated Patient
5 226 remained in the PACU for two days, requiring ICU care, until June 20, 2008, when
6 she was discharged home. Patient 226 was not admitted to an ICU bed during the
7 patient's entire length of stay.

8 A record review on July 16, 2008 for Patient 230 revealed that Patient 230,
9 a 63 year old male, was admitted to the facility pre operative unit on June 26, 2008, for
10 an elective abdominal aneurysm (a weakness in the wall of the artery) repair. Post
11 operatively, the patient had an arterial line and required ICU placement. On July 16,
12 2008, the Critical Care Unit (ICU) census report for June 26, 2008, was reviewed. The
13 report indicated the facility had eight patients in the Intensive Care Unit and two
14 additional patients in the emergency room waiting for ICU beds when Patient 230 was
15 admitted for surgery. Patient 230 was transferred to the ICU after 24 hours in the PACU.

16 During a concurrent interview with the PACU CN and the PACU Lead, on
17 July 16, 2008, at 11:50 a.m., both nurses stated the patients undergoing vascular
18 surgery and spinal fusions routinely require admission to the ICU post operatively. The
19 nurses stated they did not know if the patients would get an ICU bed post operatively
20 when the surgeries started, but they did not delay the surgeries to find out. The nurses
21 stated the facility did not have a policy requiring them to check for the availability of an
22 ICU bed before starting a surgery that would require an ICU bed postoperatively.

23 During an interview with the vascular surgeon on July 16, 2008, at 12:30
24 p.m., the surgeon stated it was common for his patients not to get an ICU bed
25 postoperatively and to stay in the PACU for their entire ICU length of stay. The surgeon
26 stated the situation was "not ideal," but he did not think he had a choice. The surgeon

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1 stated all of his patients having vascular surgical procedures required ICU care
2 postoperatively, and the facility was aware of this.

3 Respondent's conduct is a violation of its Resource Management Plan for
4 ICU patients that require that the hospital defer elective admissions requiring intensive
5 care unit care when elective surgery for patients with anticipated ICU post-operative care
6 placement was scheduled.

7 This conduct also constitutes conduct inimical to the public health, morals,
8 welfare, or safety of the people of the State of California in the maintenance and
9 operation of the premises or services for which the license is issued.

10 **X.**

11 **RESPONDENT FAILED TO PROVIDE PATIENTS WITH EMERGENCY EVALUATION**
12 **AND TREATMENT FROM SPECIALTY PHYSICIANS FORCING PATIENTS TO BE**
13 **TRANSFERRED TO OTHER HOSPITALS**

14 On April 30, 2007 at 10 am, the RSMC Emergency Department back-up
15 specialty call schedules for January, February, March and April, 2007 were reviewed by
16 Department staff. According to this schedule, the following specialties did not have a
17 formal call panel:

- 17 a. Allergy (with one physician on staff)
- 18 b. Dentistry (with one physician on staff)
- 19 c. Dermatology (with one physician on staff)
- 20 d. Endocrinology (with three physicians on staff)
- 21 e. Gastroenterology (with eleven physicians on staff)
- 22 f. Hematology/Oncology (with seven physicians on staff)
- 23 g. Infectious Diseases (with two physicians on staff)
- 24 h. Nephrology (with three physicians on staff)
- 25 i. Neurology (with three physicians on staff)
- 26 j. Ophthalmology (with three physicians on staff)
- 27 k. Oral Surgery (with three physicians on staff)

- 1 l. Pain Management (with four physicians on staff)
- 2 m. Plastic Surgery (with six physicians on staff)
- 3 n. Podiatry (with nine physicians on staff)
- 4 o. Psychiatry (with one physician on staff)
- 5 p. Pulmonology (with four physicians on staff)
- 6 q. Radiation Oncology (with three physicians on staff)
- 7 r. Rheumatology (with one physician on staff)
- 8 s. Urology (with five physicians on staff), and
- 9 t. Vascular Surgery (with two physicians on staff).

10 The Medical Staff Bylaws, approved February 26, 2007, were reviewed on
11 April 30, 2007 at 10:10 AM. The bylaws stated that "active members of the medical staff
12 must serve on the call panel rotation within their assigned department and within the
13 scope of privileges granted." A review of the Medical Staff Rules and Regulations on
14 April 30, 2007, showed that "Each active medical staff member shall actively participate
15 on and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations
16 related to patient care, including but not limited to emergency services and back-up
17 functions...."

18 The Chief Nursing Executive (CNE) was interviewed on April 30, 2007, at
19 11:35 AM. She stated that a voluntary call schedule was put into effect in August of
20 2006 by the Medical Staff and Governing Body. The CNE also stated that the transfer of
21 patients with MediCal, Medicare or no insurance, without specialty consultation, was
22 appropriate since, "these patients are supposed to have care at the county hospital."

23 The minutes of the Board of Governors were reviewed on April 30, 2007, at
24 12:30 PM. The minutes from the August 24, 2006 meeting contained a section titled "Old
25 Business-Proposed Bylaws Changes." According to the minutes, a recommendation
26 was made and approved to conduct a 90-day trial of a volunteer call panel, to provide
27 emergency coverage for the major specialty categories. The minutes from November 4,

1 2006, contained the approval by the Board of Governors to extend monitoring of the
2 Medical Staff Voluntary call process for an additional 60 days. The January 29, 2007
3 minutes extended the trial period for an additional six months.

4 Emergency Department (ED) Physician A was interviewed on April 30,
5 2007, at 2:10 PM. He stated that the lack of subspecialty call "is a daily impediment to
6 patient care." He described it as "very frustrating." He described the process by which
7 the ED physician must call all of the physicians in the needed specialty, to see if any
8 were willing to come in and see a patient needing care from that specialty. If the ED
9 physician was unable to obtain the services of the needed specialist, the "chain of
10 command" process was initiated, in which the ED physician would call the chairman of
11 Emergency Medicine, who called the Chief of Staff, who then tried to get a specialist to
12 come in and provide the necessary care. However, he stated it rarely resulted in the
13 specialty care being provided. The ED physician stated it was not effective, and it was a
14 "documenting function only," so the facility would have evidence of having exhausted all
15 efforts to obtain the needed consultation. As a result, the majority of indigent (Medi-Cal,
16 Medicare, self-pay) patients requiring specialty consultation from the categories that had
17 voluntary call, were transferred to other facilities. He stated that the ability to get
18 specialists to consult on these types of patients was drastically reduced by the initiation
19 of the voluntary call schedule, which effectively "emptied out" the call schedule. He also
20 gave the example of patients on mechanical ventilation. Many were transferred to
21 another facility, directly from the ED, because of an inability to obtain Pulmonary
22 Medicine consultation. He stated that transferring ventilated patients was "not the best
23 thing to do for the patient." He also stated that it was "embarrassing" to request that
24 another hospital accept the transfer of a patient from the ED, simply because the patient
25 was on a ventilator." He stated that the other hospitals asked him, "don't you have an
26 Intensive Care Unit (ICU) at your hospital, and can't you take care of a patient on a
27 ventilator?" The ED physician also stated that the inability to obtain orthopedic

1 consultations caused patients to be sent out of the ED with splints, to follow-up with an
2 orthopedist, or at the county hospital. This includes patients with complex fractures that,
3 with better financial circumstances, might have been admitted to the hospital for surgery,
4 or casted by an orthopedist in the ED.

5 Ten physician credential files were reviewed on April 30, 2007, at 3 PM.
6 The physicians included two gastroenterologists, two otolaryngologists, two urologists,
7 one neurosurgeon and three neurologists. All of the physicians reviewed had current
8 active privileges, and were on active staff. Of these five subspecialties, four of them
9 (gastroenterology, otolaryngology, urology and neurology) were listed on the Emergency
10 Department back-up call schedule as "optional call".

11 The minutes of the Medical Executive Committee meetings were reviewed
12 on April 30, 2007 at 4:10 PM. The minutes from April, 2006 contained discussion of a
13 voluntary call schedule. There was mention of the General Medical Staff meeting on
14 March 29, 2006, in which a discussion of voluntary call versus mandatory call took place.
15 It was stated that call had economic value and that primary care physicians were
16 concerned with the amount of uncompensated care. These issues arose again in the
17 February, 2007 minutes of the Medical Executive Committee, "The CEO discussed the
18 Chain of Command Policy indicating it was created to ensure needed patient care is
19 being provided, as per case law." There was no further discussion of the obligation to
20 respond to patient care needs.

21 The Chief of Staff (COS) was interviewed on April 30, 2007 at 5:15 PM.
22 The COS stated that many members of the medical staff had expressed that being on
23 call had become very intense, often requiring the doctor on call to have to cancel his/her
24 patients for the next day to catch up on rest. She said the medical staff was at a
25 "flashpoint" and that 80% of the members had expressed that they would not do ED
26 back-up call without some sort of reimbursement in the form of a stipend. It was for
27 these reasons that the voluntary call system was put in place. The COS stated that the

1 hospital had an initial goal of 90 days to resolve the call issues with each specialty, but it
2 has taken much longer than she had hoped, almost a year now. She agreed that she
3 needed to get more involved in the negotiation between the administration and the
4 specialty groups, since patient care was being affected.

5 The medical record for Patient 13 was reviewed on April 30, 2007. Patient
6 13, a 93 year old male, presented to the ED on March 10, 2007, at 11:30 AM, with a
7 chief complaint of "bleeding from penis." The triage assessment, completed on March
8 10, 2007, at 12:29 PM, showed that Patient 13 also complained of abdominal pain for
9 one week. The ED physician ordered a bladder scan that showed over 999 milliliters of
10 urine in Patient 13's bladder, at 5 PM. According to the ED nurse's notes, the nurse
11 caring for Patient 13 attempted to insert a catheter at 5 PM, with no success. Additional
12 attempts were made at 8:15 PM, with a 14 french coude (stiffer) catheter, and then an 18
13 french coude catheter, without success. A review of the ED physician's notes showed
14 an attempt to reach Urologist 1 to come in to assist with the care of Patient 13. Urologist
15 1 answered, and was "unavailable to care for the patient." Patient 13 was transferred to
16 another hospital at 11:55 PM, for "urology - higher level of care."

17 The medical record for Patient 14 was reviewed on April 30, 2007. Patient
18 14, a 6 year old male, presented to the ED on February 22, 2007, at 6:30 PM, with a
19 chief complaint of "stomach pains." A review of the ED nurse's notes showed Patient 14
20 was initially discharged at 8:30 PM with a diagnosis of Constipation, but the patient's
21 mother came back to the triage office at 8:38 PM, stating that Patient 14 was
22 complaining of pain to his "pee pee." Patient 14 was reevaluated, and a testicular
23 ultrasound showed that Patient 14 had a possible testicular torsion. Patient 14 was
24 called from the lobby when the ultrasound results were received, and did not answer.
25 The ED staff called Patient 14's home, and left a message regarding a "medical
26 emergency." A review of the ED physician's notes showed that Patient 14 was
27 diagnosed with Constipation and Left Testicular Torsion. Patient 14 was transferred to

1 another hospital for "higher level of care" on February 22, 2007, at 10:51 PM. A review
2 of the ED on-call schedule for February 22, 2007, done on April 30, 2007, showed that
3 no urologist was on call for the ED.

4 The medical record for Patient 15 was reviewed on May 2, 2007. Patient
5 15, a 6 year old female, presented to the ED on April 21, 2007, at 9:20 PM, with a chief
6 complaint of "right eye injury." The triage assessment, completed May 2, 2007, at 9:32
7 PM, showed that Patient 15 was "accidentally shot in the right eye" the night before.
8 Patient 15 had swelling, redness, drainage, foreign body sensation, blurred vision and
9 pain in her right eye. A review of the ED physician's notes showed that Patient 15 had a
10 hyphema (blood in the front chamber of the eye ball), and a "likely" infection in the right
11 eye. The ED physician documented that Patient 15 "will need a specialist", and "no
12 specialist available at Inland Valley, as we have no ophthalmologist on call." A review of
13 the ED physician's dictated report, dictated on April 22, 2007, at 12:21 AM, showed that
14 "we do not have an ophthalmology specialist at this hospital. Because of this, this patient
15 does need ophthalmology higher level of care...I will be transferring this patient to (name
16 of another acute hospital) for higher level of care." Patient 15 was transferred to another
17 hospital for care on April 22, 2007, at 2:08 AM. A review of the Medical Staff list of
18 ophthalmologists at the hospital on April 30, 2007, showed that two of two ophthalmologists
19 listed on the Medical Staff were listed as "active".

20 The medical record for Patient 16 was reviewed on May 2, 2007. Patient
21 16, a 57 year old female, presented to the ED on January 9, 2007, at 3:45 AM, with a
22 chief complaint of "sharp pain at left leg, abdominal pain and vomiting". The triage
23 assessment, completed on January 9, 2007, at 4:11 AM, showed that Patient 16 had non
24 provoked left lower quadrant pain, with a sudden onset, for 3 hours. At 4:36 AM, the ED
25 nurse's notes showed that Patient 16 was "moaning, complaining of lower left abdominal
26 pain." The ED physician's notes showed that Patient 16 had, "infected stone, high grade

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1 obstruction", and "no urology on call." The patient was transferred to another hospital for
2 care on January 9, 2007, at 11:26 AM.

3 The medical record for Patient 17 was reviewed on May 2, 2007. Patient
4 17, a 48 year old male, presented to the ED on November 14, 2006, at 7:02 PM, arriving
5 by ambulance, with a chief complaint of vomiting blood, and blood in stool. Patient 17's
6 blood pressure, when the ambulance arrived at his home, was 78/0 (low). The
7 paramedic started two intravenous (IV) lines, and started giving intravenous fluids. The
8 triage assessment, completed on November 14, 2006, at 7:21 PM, showed that Patient
9 17 had a history of liver disease, and was experiencing abdominal pain, vomiting blood
10 for two days, and was dizzy. A nasogastric tube (a tube inserted through a nostril, and
11 down into the stomach) was inserted at 10:01 PM, and tested positive for blood in the
12 stomach contents. Patient 17 had an elevated Blood Urea Nitrogen (BUN, indicating
13 dehydration), a low hemoglobin (number of oxygen carrying blood cells in the vessels,
14 that decreases further with hydration) and an elevated Pro time (indicating a likelihood
15 for further bleeding, due to longer clotting times). His blood pressure at 1 AM was 95/68.
16 Patient 17 was transferred to another hospital for care at 2:50 AM, after two liters of fluid
17 had infused, with a blood pressure of 95/68, in the care of a "Critical Care Transport
18 Team", as ordered by the ED physician. A review of the Emergency on-call schedule for
19 November 14, 2006, showed that no Gastroenterologist was on call for the ED.

20 Respondent's actions of transferring indigent (Medi-Cal, Medicare, self-
21 pay) patients and discharging patients in splints due to inability to obtain orthopedic
22 consultations placed patients at risk of serious injury or illness and constitutes conduct
23 inimical to the public health, morals, welfare, or safety of the people of the State of
24 California in the maintenance and operation of the premises or services for which the
25 license is issued. This conduct is also a violation of Health and Safety Code sections
26 1317, 1317.2, and 1317.3.

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1 Pursuant to Health and Safety Code section 1317:

2 "(a) Emergency services and care shall be provided to any
3 person requesting the services or care, or for whom services
4 or care is requested, for any condition in which the person is
5 in danger of loss of life, or serious injury or illness, at any
6 health facility licensed under this chapter that maintains and
operates an emergency department to provide emergency
services to the public when the health facility has appropriate
facilities and qualified personnel available to provide the
services or care.

7 (b) In no event shall the provision of emergency services and
8 care be based upon, or affected by, the person's ethnicity,
9 citizenship, age, preexisting medical condition, insurance
10 status, economic status, ability to pay for medical services,
11 or any other characteristic listed or defined in subdivision (b)
or (e) of Section 51 of the Civil Code, except to the extent
that a circumstance such as age, sex, preexisting medical
condition, or physical or mental
disability is medically significant to the provision of
appropriate medical care to the patient.

12 Pursuant to Health and Safety Code section 1317.2:

13 "No person needing emergency services and care may be
14 transferred from a hospital to another hospital for any
15 nonmedical reason (such as the person's inability to pay for
any emergency service or care) unless each of the following
conditions are met:

16 (a) The person is examined and evaluated by a physician
and surgeon, including, if necessary, consultation, prior to
transfer.

17 (b) The person has been provided with emergency services
18 and care so that it can be determined, within reasonable
19 medical probability, that the transfer or delay caused by the
transfer will not create a medical hazard to the person..."

20 Pursuant to Health and Safety Code section 1317.3:

21 (b) As a condition of licensure, each hospital shall adopt a
22 policy prohibiting discrimination in the provision of
23 emergency services and care based on ethnicity, citizenship,
24 age, preexisting medical condition, insurance status,
25 economic status, ability to pay for medical services, or any
26 characteristic listed or defined in subdivision (b) or (e) of
Section 51 of the Civil Code, except to the extent that a
circumstance such as age, sex, preexisting medical
condition, or physical or mental disability is medically
significant to the provision of appropriate medical care to the
patient.

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1 (c) As a condition of licensure, each hospital shall require
2 that physicians and surgeons who serve on an "on-call"
3 basis to the hospital's emergency room cannot refuse to
4 respond to a call on the basis of the patient's ethnicity,
5 citizenship, age, preexisting medical condition, insurance
6 status, economic status, ability to pay for medical services,
7 or any characteristic listed or defined in subdivision (b) or (e)
8 of Section 51 of the Civil Code, except to the extent that a
9 circumstance such as age, sex, preexisting medical
10 condition, or physical or mental disability is medically
11 significant to the provision of appropriate medical care to the
12 patient..."

13 XI.

14 **RESPONDENT'S RSMC EMERGENCY DEPARTMENT LIST OF BACK-UP 15 SPECIALTY PHYSICIANS FAILED TO IDENTIFY THE PHYSICIAN RESPONSIBLE 16 FOR THE HOSPITALIST'S BACK-UP ON CALL FOR PATIENTS REQUIRING 17 HOSPITALIZATION**

18 During a tour of the RSMC ED on 1/13/10 at approximately 2:00 pm, a
19 daily on call back-up physician by specialty schedule was requested. M49 produced a
20 schedule that failed to list the name of the physician responsible for the hospitalist back-
21 up on-call for patients requiring hospitalization. The hospitalist back-up was only
22 identified as a computer website and did not list an individual doctor. The staff were
23 required to enter their request for a hospitalist in the computer on the hospital intranet.
24 M49 agreed that the ED staff did not know how to contact the hospitalist group in the
25 case of electrical outage or other times when the computer might not be functioning.

26 XII.

27 **SURGICAL INSTRUMENTS WERE NOT PROPERLY STERILIZED**

During a scheduled tour of RSMC, technicians admitted that they were not
aware of the need to check the expiration dates of cleaners or to accurately measure the
amount of cleaner necessary to sterilize instruments.

On October 2, 2007 at 3:20 p.m., a technician was observed washing
instruments and was interviewed about the procedure she followed. The technician
stated the washing sink held about six quarts of water, and when she mixed the solution

1 for decontamination of surgical instruments in this sink, she added, "a few squirts," of
2 Ultrazyme cleaner to the water. The technician stated there was no measured amount of
3 solution added to the water, sometimes she added more, and sometimes she added
4 less. A review of the manufacturer's recommendations on the Ultrazyme bottle indicated
5 one ounce (one pump) of cleaner should be added to each gallon of water. The
6 technician was not aware of the need to accurately measure the amount of enzymatic
7 cleaner to be added to a known amount of water.

8 During the same tour, the other side of the instrument pre-wash area was
9 identified as the area for washing TEE probes (used to do a cardiac ultrasound from
10 inside the esophagus). The SPD technician stated the cardiology technicians were
11 responsible for cleaning these instruments. The technician stated Cidex was used as
12 the enzymatic cleaner for this procedure. The technician identified a bottle of test strips
13 used to verify the concentration of the cleaner after mixing. The date on the bottle of test
14 strips indicated they had expired. The hospital policy on cleaning TEE probes was
15 reviewed on October 2, 2007. The policy indicated the probes should be cleaned with
16 one to two ounces of enzymatic cleaner per gallon of water. However, the bottle of
17 Cidex specified one ounce of cleaner per gallon of water. The technician stated the old
18 cleaner was mixed with one to two ounces of solution per gallon of water, and the policy
19 was outdated.

20 In the same area, a cart was observed with a towel on top. Clean
21 endoscopes were observed curled up in the towel. The clinical lead for Surgical
22 Services stated the old cabinet for hanging the endoscopes had to be discarded, and
23 they were awaiting approval of the capital budget to purchase a new one. In the
24 meantime, the scopes were stored in this manner. The clinical lead agreed that
25 endoscopes should be stored in an upright hanging position to ensure that moisture from
26 condensation does not collect in the chambers, forming a place for microbes to grow.
27 She stated "we have to wait for a new cabinet; there is no other place to put them."

1 The Endoscopy Lab (used for scoping procedures of the stomach and
2 colon) at IVMC was toured on October 4, 2007, at 3:30 p.m. The Endo technician was
3 questioned regarding the cleaning of the endoscopes. The tech stated the first step
4 involved soaking the scopes and cleaning them with an enzymatic cleaning solution.
5 The cleaner present in the cleaning area was V. Mueller Dual Enzy Clean, and the
6 instructions called for one to two pumps (ounces) per gallon of water. The technician
7 described he would fill the sink with water and add about 10 pumps of solution to the sink
8 water. He stated he did not remember how he was taught the mixing procedure. He
9 stated he did not recall having this part of his job checked with his annual competencies
10 or his evaluation.

11 During a tour of the sterile processing department at IVMC on July 15,
12 2008, SPD Tech 1 was observed from 2:35 p.m. to 3:10 p.m. cleaning, disinfecting, and
13 prepping surgical instruments that had been used in a surgical procedure. The SPD
14 Tech removed, from a procedure tray, instruments that he assumed had been directly
15 used in a surgical procedure and placed them in a cleansing solution. The SPD Tech left
16 instruments he assumed were not directly used in a surgical procedure in the bottom of
17 the procedure tray. The instruments left in the bottom of the procedure tray included a
18 set of at least 15 to 20 clamps/scissors that were bunched together with a longer set of
19 clamps inserted through the handle to hold the set together. The clamps and scissors
20 were closed and the interior surfaces were not exposed. The SPD Tech scrubbed and
21 washed the instruments he soaked in the cleansing solution and then placed them on top
22 of the instruments he left in the procedure tray. The SPD Tech did not soak the
23 instruments left in the procedure tray, open the instruments to expose all surfaces, nor
24 did he closely inspect those instruments he assumed were not soiled with biomatter.

25 During a concurrent interview, the SPD Tech stated he does not put all
26 instruments in the cleansing solution and scrub them. He stated he only puts them in the
27 solutions and scrubs them if he sees biomatter on the outside of the instruments.

1 To clean the air hoses and other flexible hosing, the SPD Tech squirted
2 full-strength Cavicide (a cleaning agent used for cleaning the surgical instruments) from
3 the pump bottle directly on the hoses. (The directions on the full-strength Cavicide pump
4 bottle indicated the solution should be mixed in a concentration of 1 ounce per liter of
5 water.) He then wiped the hoses with his gloved hands, rinsed the hoses off under
6 running water, and wiped the hoses with a dry washcloth. The SPD Tech then used
7 pressurized air on the hoses while holding them up in the air, causing a fine mist of liquid
8 to come off the hoses and into the surrounding air, falling onto surrounding objects.

9 The SPD Tech took a pre-mixed spray bottle of Cavicide and sprayed a
10 mist on empty surgical procedure trays. He then immediately wiped the trays off. The
11 directions on the spray bottle indicated the Cavicide was to stay wet on the surface at
12 least 30 seconds. The SPD Tech then sprayed some Cavicide on a washcloth and
13 wiped the top of a tray.

14 During an interview with SPD Tech 2 on July 16, 2008, at 10:30 a.m., she
15 stated the OR staff put a surgical towel on top of the unused instruments and then
16 placed the used instruments on top of the towel. This procedure results in the potential
17 for blood and other biomatter to drip down or drop down onto the "unused" instruments
18 at the bottom of the procedure tray.

19 During an interview with the Director of Perioperative Services on July 15,
20 2008, at 4:30 p.m., she stated all the instruments returning from an OR procedure should
21 be soaked in the cleansing solution. She also stated the clamps and scissors should be
22 opened so all surfaces were exposed to cleaning and disinfecting. She also stated the
23 SPD tech should be following the directions for the use of the cleansing agents, including
24 making proper concentrations and leaving the surface wet for the amount of time
25 recommended by the manufacturer. The Director stated the SPD Tech should not have
26 been spraying hoses dry in such a manner as to cause a fine mist of liquid in the air.

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1 The policy and procedure titled "Cleaning and sterilizing equipment and
2 supplies," dated April 2008, stated in the section titled "decontamination," initial manual
3 cleaning was to be done on all instruments." The policy and procedure also stated that
4 solutions were to be mixed and used as recommended by the manufacturer. The policy
5 and procedure did not have directions to the staff regarding how clamps and other
6 instruments should be left open in order to expose all surfaces to cleaning.

7 During a tour of the GI Lab on July 15, 2008, at 2 p.m., GI Tech 1
8 demonstrated how she cleaned the GI scopes. The Tech explained she put two
9 "pumps," of the cleaner in each gallon of water. When measured, one pump was 20
10 cc's, which would be 40 cc's per gallon of water. The directions on the cleanser
11 indicated the concentration was to be 30 cc's (1 ounce) per gallon. The facility policy
12 and procedure for cleaning endoscopes indicated staff were to follow the manufacturer's
13 directions for mixing cleansing solutions.

14 This conduct could result in the use of improperly sterilized instruments
15 during patient procedures and constitutes conduct inimical to the public health, morals,
16 welfare, or safety of the people of the State of California in the maintenance and
17 operation of the premises or services for which the license is issued. This conduct is
18 also a violation of title 22 CCR sections 70739(a) and 70831(c). Section 70739 provides
19 as follows:

20 (a) A written hospital infection control program for the
21 surveillance,
22 prevention and control of infections shall be adopted and
23 implemented..."
24 (b) The oversight of the infection surveillance oversight
25 program shall be vested in a multi-disciplinary committee
26 which shall include representatives from the medical staff,
27 nursing department and infection control personnel. The
committee shall provide advice on all proposed construction
and shall be responsible for the provision of current updated
information on infection control policy and procedures for the
facility."

Pursuant to 22 CCR section 70831:

1 “(c) There shall be written procedures developed and
2 maintained pertaining to the cleaning, preparation,
3 disinfection, and sterilization of utensils and instruments.”

4 **XIII.**

5 **EXPIRED INSTRUMENTS WERE STORED WITH
6 THE SUPPLIES FOR PATIENT USE**

7 During a tour of RSMC on October 3, 2007, at 10 a.m., Department staff
8 observed that multiple wrapped angiocatheters and other equipment for use in the
9 Special Procedures/Cardiac Cath suite were stored in both the CT room and the special
10 procedures room. Examination of the supplies in the CT room revealed three Cordis 6
11 French angiocaths had expired three months prior to survey. Examination of the
12 supplies in the Special Procedures room revealed six Cook 5 French angiocaths, four
13 expired 8 months prior to the survey, and the other two expired 5 months prior to the
14 survey.

15 The Radiology Suite at IVMC was toured on October 4, 2007, at 2 p.m.
16 Examination of the supplies in the room revealed one Vista 8 French endovascular
17 catheter with an expiration date of September 2007, indicating that the period for safe
18 use had ended 4 days prior. Three biliary stents (used to catheterize the gall bladder)
19 were also expired September 2007. The staff were unable to explain why the expired
20 instruments were stored with the supplies for patient use.

21 This conduct could result in the use of expired instruments in patient
22 procedures and constitutes conduct inimical to the public health, morals, welfare or
23 safety of the people of the State of California in the maintenance and operation of the
24 premises or services for which the license is issued.

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1 XIV.

2 **OUTDATED, MISLABELED, OR OTHERWISE UNUSABLE DRUGS AND**
3 **BIOLOGICALS WERE AVAILABLE FOR PATIENT USE**

4 During a review of medications stored on the anesthesia cart in Operating
5 Room 2 at RSMC on October 2, 2007, at 2:45 p.m., seven undated vials of Atracurium (a
6 medication used as an adjunct in surgery) and four undated vials of succinylcholine (a
7 medication used as an adjunct in surgery) were observed to be stored at room
8 temperature. Both the Atracurium and the succinylcholine have a limited stability when
9 stored outside a refrigerator. The facility lacked a system to determine how long these
10 drugs had been stored at room temperature, and therefore could not ensure the stability
11 or potency of either agent.

12 Pursuant to title 22 CCR 70263:

13 "(c) The [pharmacy and therapeutics committee] "(1) ...shall
14 develop written policies and procedures for establishment of
15 safe and effective systems for procurement, storage,
16 distribution, dispensing and use of drugs and chemicals.
17 **The pharmacist in consultation with other appropriate**
18 **health professionals and administration shall be**
19 **responsible for the development and implementations of**
20 **procedures.** Policies shall be approved by the governing
21 body. Procedures shall be approved by the administration
22 and medical staff where such is appropriate.
23 (2) The committee shall be responsible for the development
24 and maintenance of a formulary of drugs for use through the
25 hospital." (emphasis added)

26 During a review of medications stored on the anesthesia cart in Operating
27 Room 3 at RSMC on October 2, 2007, at 2:50 p.m., one undated vial of succinylcholine,
one undated vial of Zemuron (a drug used as an adjunct in anesthesia) and seven
undated vials of Atracurium were stored at room temperature. Atracurium, Zemuron and
succinylcholine have a limited stability when stored outside a refrigerator. The facility
lacked a system to determine how long these drugs had been stored at room
temperature, and therefore could not ensure the stability or potency of either agent.

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1 During a review of medications stored on the anesthesia cart in L&D at
2 RSMC on October 2, 2007, at 3:20 p.m., two vials of succinylcholine and three vials of
3 Zemuron were stored at room temperature. The facility lacked a system to determine
4 how long these drugs had been stored at room temperature, and therefore could not
5 ensure the stability or potency of either agent.

6 The Operating Room Suite at RSMC was toured on October 2, 2007, at
7 2:35 p.m. There were bags of intravenous (IV) solutions stored on a cart in a small
8 storage area. One bag, labeled "5% Dextrose, 1000 ml," had an expiration date of May
9 2006.

10 At RSMC, on 1/11/10 at 11:00 a.m., during a tour of the main pharmacy, an
11 intravenous (IV) antibiotic medication was found in the IV room refrigerator. The
12 medication was Gentamicin 600 milligrams in 250 milliliters of Normal Saline and found
13 to have expired on 1/10/10. The medication was in the refrigerator and available to be
14 dispensed to Patient 18. After Departmental staff identified the expired medication, the
15 DOP (Director of Pharmacy) removed it from the refrigerator.

16 On 1/12/10 at 2:17 p.m., while inspecting the IVMC Pharmacy, inspection
17 of a bin containing Xopenex (for use in inhalation nebulizer machines in order to open
18 restricted airways) revealed that one foil pouch containing seven unit dose pillows was
19 open and two more pillows were stored openly in the bin outside of the foil pouch in
20 which the manufacturer packaged them. A label on the carton that held the foil pouches
21 stated that these vials were to be used within two weeks if stored in an open foil pouch
22 and within one week if stored outside of the foil pouch. During a concurrent interview
23 E109 stated that the foil pouches were to be dated when opened (so the more rapid
24 expiration could be tracked). He stated that the pillows outside the foil pack should have
25 been discarded. There was no date on the foil pack. During an interview of M32 at this
26 time he stated that the foil pouches of Xopenex were required to be dated by staff when
27 opened. He stated he did not know how long these pillows had been stored in the open

1 pouch or outside the pouch and that there was no way to determine this. He then
2 discarded the nine pillows.

3 On 1/11/10 at 2:43 p.m. during an inspection of the RSMC Surgery
4 Department, expired sponges were found in an open box labeled to contain 30 Scrub
5 Care Sponges. The expiration dates on the sponges were 9/2007 (two years and three
6 months prior to the survey). During an interview of M22 at this time she stated that
7 although the sponges were over a "backup" sink they potentially could be used. These
8 sponges are for use by physicians and nurses to scrub before surgery.

9 On 1/12/10 at 2:42 p.m. at IVMC an inspection of the Malignant
10 Hyperthermia (MH) cart in the PACU revealed that the expiration date documented on
11 the content list for Furosemide (used to increase urine flow) was 2/1/11. Inspection of
12 the medication tray indicated the manufacturer's expiration date on all four of the vials
13 was 4/1/10.

14 The hospitals' policies and procedures related to large volume IV fluids
15 stated that if the IV bag's outer protective cover was removed and the IV was not used
16 immediately, the bag was to be dated and discarded after 30 days. On 1/13/10 at 11:00
17 a.m., the ICU supply cart at IVMC was inspected. There were two 1000 ml bags of
18 normal saline without a protective cover. There was no date identifying when the bags
19 had been removed from the protective cover. During a concurrent interview with M51,
20 she stated if the bags were opened and not used they were to be dated and discarded
21 after 30 days.

22 The use of outdated, undated, or improperly dated drugs or biologicals
23 exposes patients to risks including infection and constitutes conduct inimical to the public
24 health, morals, welfare, or safety of the people of the State of California in the
25 maintenance and operation of the premises or services for which the license is issued.
26 This conduct is also a violation of title 22 CCR section 70263 which provides as follows:

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1 aureus). On page two direction was given that the following patients must be tested
2 within 24 hours of admission:

3 Any patient scheduled to undergo an inpatient surgery.

4 Any patient who has been previously discharged from a general acute care
5 hospital within 30 days prior to the current hospital admission.

6 Any patient being transferred from a skilled nursing facility.

7 Any patient admitted to ICU, NICU units (Intensive care unit, neonatal
8 intensive care unit).

9 Any patient who receives inpatient dialysis or outpatient dialysis treatment.

10 Any patient who has a prior history of MRSA infection.

11 On 1/12/10 at 9:10 a.m., an interview was conducted with E26, an Infection
12 Preventionist at the RSMC campus. E26 was asked to describe the MRSA screening
13 process in accordance with their policy and procedure. E26 stated that neither of the two
14 hospital campuses tracked compliance with their MRSA policy. E26 further stated that
15 the two hospital campuses had no idea what their MRSA policy and procedure
16 compliance was.

17 Failure to test patients for MRSA places patients and staff at risk of
18 contracting infection or illness from this infectious bacteria and constitutes conduct
19 inimical to the public health, morals, welfare or safety of the people of the State of
20 California in the maintenance and operation of the premises or services for which the
21 license is issued.

22 XVII.

23 EQUIPMENT NECESSARY FOR EMERGENCY RESUSSITATION 24 NOT AVAILABLE IN LABOR AND DELIVERY

25 During a tour of the Labor and Delivery Room across from the Nursery at
26 RSMC, conducted on 1/11/10 at 10:00 a.m. with E45 and M54, Department staff
27 observed that the anesthesia machine did not have an Ambu bag. An Ambu bag is a

1 hand-held device used to provide positive pressure ventilation to a patient who is
2 breathing inadequately (respiratory failure) or has ceased breathing completely
3 (respiratory arrest). The device is a normal part of a resuscitation kit and is an essential
4 part of a crash cart. It is used extensively in the operating room to ventilate an
5 anaesthetized patient in the minutes before a mechanical ventilator is attached.

6 E45 had to step out of the room to provide the necessary equipment.

7 This lack of resuscitation equipment places patients in risk of serious harm
8 and constitutes conduct inimical to the public health, morals, welfare or safety of the
9 people of the State of California in the maintenance and operation of the premises or
10 services for which the license is issued.

11 XVIII.

12 PATIENTS WERE NOT GIVEN MEDICATIONS AS 13 PRESCRIBED BY THEIR PHYSICIAN

14 During a review of Patient 702's emergency room record at the RSMC
15 campus on October 2, 2007, beginning at 10:20 a.m., it was noted that on October 1,
16 2007, at 7 p.m., the physician ordered Dilaudid (a potent opiate narcotic used for the
17 relief of pain) 2 mg intravenously every 2 hours for mild pain, 3 mg intravenously every 2
18 hours for moderate pain and 4 mg every 2 hours for severe pain. Documentation in the
19 medical record section entitled "nursing procedure: medication" revealed a dose of 1 mg
20 of Dilaudid was administered at 1:15 a.m. on October 2, 2007.

21 Nurse A, who administered the 1 mg dose, was interviewed on October 3,
22 2007 at 4:45 p.m. The nurse confirmed that there was no physician's order to administer
23 Dilaudid 1 mg. She reported that the patient had previously received Dilaudid 3 mg but
24 appeared to have difficulty tolerating the dose, so she gave only 1 mg. Nurse A stated
25 that she realized later that the physician had ordered Dilaudid 2 mg. She stated she
26 should have called or spoken with the physician for an order for a lower dose.

27 ///

1 During observation of medication administration on October 4, 2007, at
2 9:08 a.m., at the IVMC campus, the medication nurse administered Lovenox 80 mg (a
3 drug used to prevent blood clotting) subcutaneously to Patient 709. When the
4 observations of the medication administration were reconciled with the physician orders
5 on October 4, 2007, at 10 a.m., it was noted that the physician had ordered Lovenox 150
6 mg, not 80 mg. A review of the MAR showed 80 mg of Lovenox had been administered
7 every 12 hours since it was ordered on September 30, 2007, at 4:45 p.m. A review of
8 the order showed that the Lovenox dose appeared to have been written over and
9 initialed. Pharmacy Staff C provided an original copy of the order from September 30,
10 2007, which showed that the prescriber had originally ordered Lovenox 80 mg. At some
11 unknown date and time, the prescriber wrote over and changed the original dose.
12 During an interview with Pharmacy Staff C on October 4, 2007, at 10 a.m., Pharmacy
13 Staff C agreed that the current order for Lovenox was 150 mg, but that the prescriber
14 should have discontinued the previous order and written an order for the new dose. The
15 manner in which the prescriber changed the order directly contributed to the wrong dose
16 of Lovenox being given for an undetermined time.

17 During record review on October 4, 2007, beginning at 2 p.m., in the ICU of
18 the IVMC campus, it was noted that Patient 801 had an order to receive labetalol (a drug
19 used to treat high blood pressure) intravenously. The order specified to hold the
20 labetalol if the systolic blood pressure was below 140 mm Hg. Documentation in the
21 medication administration section of the nursing progress notes showed Patient 801's
22 systolic blood pressure was below 140 mm Hg at 12:50 a.m. on October 1, 2007. The
23 labetalol continued to be administered until 1:06 a.m. (an additional 16 minutes), at
24 which time Patient 801's blood pressure was noted to be 47/23 and a "code blue was
25 called". Documentation in the medical record showed the labetalol was not held until the
26 code blue was called. Nurse B, who administered the medication, was off duty at the
27 time of the review, and was interviewed by phone at 3 p.m., on October 4, 2007. Nurse

1 B confirmed that the labetalol had continued to be administered even when the systolic
2 blood pressure was below 140 mm Hg.

3 On October 4, 2007, at 9:50 a.m., it was noted by Departmental staff that
4 Patient 711 had not been given a scheduled dose of Reglan at 10 p.m. on October 3,
5 2007. On October 4, 2007, at 10 a.m., Pharmacy Staff C verified this observation.

6 During a review of Patient 802's emergency room record at IVMC,
7 beginning at 4 p.m. on October 4, 2007, it was noted that the emergency room physician
8 ordered 2 mg of Dilaudid on October 4, 2007, at 11:20 a.m. The Dilaudid was ordered
9 for a pain level of 7 of 10. The patient's pain level was 7. The Dilaudid was not
10 administered until 12:46 p.m. (1 hour and 26 minutes after being ordered). When
11 interviewed on October 4, 2007, at 4:30 p.m., Nurse C reported she was at lunch when
12 the order was written. Nurse C stated that when she returned from lunch, she was
13 assigned three patients - one with chest pain, one with congestive heart failure and
14 Patient 802 who had abdominal pain. Due to the clinical need of the first two patients,
15 she reported she needed to assess and provide care to these patients first. Nurse C
16 stated that waiting over an 1 hour and 20 minutes for pain control was too long.

17 On July 14, 2008, at 2:15 p.m., a review of Patient 507's record was
18 conducted in the ICU at RSMC. There was a written physician's order dated July 11,
19 2008, at 5:30 p.m. for NTG (nitroglycerin) drip to start at 7mcg/min and titrate to maintain
20 the patient's systolic blood pressure less than or equal to 120 mm Hg. A review of
21 ICU/PCU Flow Sheet which documented the flow rate of the NTG every hour contained
22 the following for the NTG given from July 11, 2008, at 6 p.m., to July 12, 2008, at 7 a.m.:

23 6 p.m. - 7 mcg;
24 7 p.m. - 7 mcg;
25 8 p.m. - 10 mcg;
26 9 p.m. - 15 mcg;
27 10 p.m. - 18 mcg;
11 p.m. - 18 mcg;
12 p.m. - 18 mcg;
1 a.m. - 18 mcg;
2 a.m. - 18 mcg;

1 3 a.m. - 18 mcg;
2 4 a.m. - 18 mcg;
3 5 a.m. - 18 mcg,
4 6 a.m. - 15 mcg.

5 On July 14, 2008 at 4:15 p.m., a review of the hospital's Policy and
6 Procedures titled "Medication: Ordering, Transcription and Administration of,"
7 documented the following:

8 "A. Medication Order Initiation:
9 (4) The following elements must be present in any
10 medication order, including...
11 (d) Frequency of administration/rate...
12 (8) Specific Order Types...;
13 (c) Titrate orders: order to dose a drug to a specific
14 parameter (i.e. BP) by incremental rate increases.
15 Execution of titrate orders will be guided by approved dosing
16 guidelines (policy NUR-14) that specify correct start rate,
17 how to adjust rates, etc."

18 On July 14, 2008, at 2:30 p.m., during an interview with the Director of
19 Pharmacy (DOP) and RN 500, both stated the Physician's NTG order for Patient 507
20 was incomplete. The DOP and RN 500 stated the titration parameter was not specific
21 enough and that it was their expectation the order should have been clarified by nursing
22 or pharmacy staff by contacting the ordering Physician. The DOP and RN 500 stated the
23 staff nurse who titrated the NTG drip did not follow the guideline for NTG as evidenced
24 by the rate increase from 7 mcg/min to 10 mcg and from 15 mcg to 18 mcg as
25 documented on the ICU/PCU Flow Sheet.

26 The record for Patient 201 was reviewed on August 26, 2009. Patient 201,
27 a 35 year old male, was admitted to the ICU on July 18, 2009, with diagnoses that
included respiratory failure. The ICU flowsheet indicated the patient required intubation
(a tube inserted into the trachea to assist with breathing), and sedation with propofol (a
hypnotic medication used for sedation in patients on ventilators) at 11 a.m. a physician's
order dated July 18, 2009, indicated the propofol was to be titrated (increased or
decreased) to maintain a Ramsay score of three (the Ramsay scale scores the level of

1 sedation according to how rousable the patient is. A score of three means the patient
2 responds to commands). The ICU flowsheets indicated the propofol drip was managed
3 as follows:

4 On August 18, 2009:

5 11 a.m., started at 20 mcg/kg/min, no Ramsay score was
6 documented;
7 12 noon, decreased to 10 mcg/kg/min, no Ramsay score
8 was documented;
9 1 p.m. and 2 p.m., decreased to 8.3 mcg/kg/min, no Ramsay
10 score was documented;
11 3 p.m. and 4 p.m., increased to 20 mcg/kg/min, no Ramsay
12 score was documented;
13 5 p.m., decreased to 18 mcg/kg/min, then to 16 mcg/kg/min,
14 no Ramsay score was
15 documented;
16 6 p.m. and 7 p.m., increased to 24.2 mcg/kg/min, no
17 Ramsay score was documented;
18 8 p.m. through 2 a.m., increased to 36 mcg/kg/min, no
19 Ramsay score was documented;
20 3 a.m. and 4 a.m., increased to 50 mcg/kg/min, no Ramsay
21 score was documented; and,
22 5 a.m. through 7 a.m., increased to 100 mcg/kg/min
23 (doubled), no Ramsay score was documented.

24 On August 19, 2009:

25 8 a.m., decreased to 30 mcg/kg/min, no Ramsay score was
26 documented;
27 9 a.m., decreased to 25 mcg/kg/min, no Ramsay score was
documented;
10 a.m., decreased to 20 mcg/kg/min, no Ramsay score was
documented;
11 a.m., increased to 90 mcg/kg/min, then decreased to 80
mcg/kg/min, no Ramsay score was documented;
12 noon and 1 p.m., stayed at 80 mcg/kg/min, no Ramsay
score was documented;
2 p.m., decreased to 70 mcg/kg/min, no Ramsay score was
documented;
3 p.m., decreased to 60 mcg/kg/min, no Ramsay score was
documented;
4 p.m. and 5 p.m., decreased to 50 mcg/kg/min, no Ramsay
score was documented;
6 p.m. and 7 p.m., increased to 60 mcg/kg/min, no Ramsay
score was documented;
8 p.m., increased to 60 mcg/kg/min, then to 80 mcg/kg/min,
no Ramsay score was
documented;

///

1 9 p.m. and 10 p.m., increased to 90 mcg/kg/min, no
2 Ramsay score was documented;
3 11 p.m., decreased to 80 mcg/kg/min, no Ramsay score was
4 documented;
5 12 midnight through 2 a.m., increased to 90 mcg/kg/min, no
6 Ramsay score was documented; and,
7 3 a.m. through 7 a.m., increased to 100 mcg/kg/min, no
8 Ramsay score was documented.

9 A physician's order dated August 20, 2009, indicated the propofol was to
10 be titrated to maintain a Ramsay score of 5 (the patient exhibits a sluggish response to a
11 light tap between the eyebrows or a loud sound). The ICU flowsheet dated August 22,
12 2009, indicated the propofol was infusing at 100 mcg/kg/min from 7 p.m. to 7 a.m., and
13 no Ramsay score was documented. The ICU flowsheet dated July 29, 2009, indicated
14 the propofol was infusing at 80 mcg/kg/min from 7 a.m. until 11 a.m., when it was turned
15 off.

16 The record for Patient 215 was reviewed on August 25, 2009. Patient 215,
17 a 21 year old male, was admitted to the facility on August 15, 2009, with a stab wound.
18 The ICU flowsheet indicated the patient required intubation (a tube inserted into the
19 trachea to assist with breathing) and sedation with propofol (a hypnotic medication used
20 for sedation in patients on ventilators). A physician's order dated August 15, 2009,
21 indicated the propofol was to be titrated (increased or decreased) to maintain a Ramsay
22 score of four. A score of four means the patient exhibits a brisk response to a light tap
23 between the eyebrows or a loud sound). The ICU flowsheets indicated the propofol drip
24 was managed as follows:

25 On August 16, 2009:

26 7 a.m. through 11 a.m., infusing at 60mcg/kg/min, no
27 Ramsay score was
documented;
12 noon and 1 p.m., decreased to 58 mcg/kg/min, no
Ramsay score was documented;
2 p.m. and 3 p.m., decreased to 56 mcg/kg/min, no Ramsay
score was documented;
4 p.m. and 5 p.m., decreased to 54 mcg/kg/min, no Ramsay
score was documented; and,

1 7 p.m. through 7 a.m., increased to 60 mcg/kg/min, no
Ramsay score was documented.

2 On August 17, 2009:

3 7 a.m. through 7 p.m., infused at 60 mcg/kg/min, no Ramsay
score was documented;

4 8 p.m., increased to 70 mcg/kg/min, no Ramsay score was
documented; and,

5 9 p.m. through 7 a.m., infused at 70 mcg/kg/min, no Ramsay
score was documented.

6
7 On August 18, 2009:

8 7 a.m. through 9 a.m., infusing at 70 mcg/kg/min, no

Ramsay score was documented;

9 10 a.m., decreased to 60 mcg/kg/min, no Ramsay score was
documented;

10 11 a.m., decreased to 50 mcg/kg/min, no Ramsay score was
documented;

11 12 noon through 2 a.m., infusing at 50 mcg/kg/min, no

Ramsay score was documented;

12 3 a.m., increased to 60 mcg/kg/min, no Ramsay score was
documented; and,

13 4 a.m. through 7 a.m., infusing at 60 mcg/kg/min, no
Ramsay score was documented.

14 A physician's order dated August 20, 2009, indicated the propofol was to
15 continue, versed (a sedative) was to be added, and the combined drips were to be
16 titrated to a Ramsay score of three (the patient responds to commands). The ICU
17 flowsheet dated August 20, 2009, indicated the propofol infused at 59 mcg/kg/min until
18 11 a.m., when it was turned off. The versed drip continued. No Ramsay score was
19 documented.

20 The ICU flowsheet dated August 21, 2009, indicated the propofol was
21 turned back on at 9:10 a.m. The ICU flowsheets indicated the propofol drip was
22 managed as follows:

23 On August 21, 2009:

24 9:10 a.m., started at 20 mcg/kg/min, no Ramsay score was
documented;

25 10 a.m., increased to 30 mcg/kg/min, no Ramsay score was
documented;

26 11 a.m. and 12 noon, increased to 35.1 mcg/kg/min, no
Ramsay score was documented;

1 1 p.m. through 3 p.m., increased to 38.7 mcg/kg/min, no
2 Ramsay score was documented;
3 4 p.m. through 6 p.m., decreased to 37.2 mcg/kg/min, no
4 Ramsay score was documented; and,
5 7 p.m. through 7 a.m., infusing at 37.2 mcg/kg/min.

6 The nurse documented a Ramsay score of four at 7 p.m., 8 p.m. and 9
7 p.m. (more sedate than ordered by the physician). No Ramsay score was documented
8 from 10 p.m. through 7 a.m.

9 On August 22, 2009, 7 a.m. through 7 p.m., infusing at 37.2 mcg/kg/min, no
10 Ramsay score was documented. At 7 p.m., the nurse documented a Ramsay score of
11 three-four (more sedate than ordered by the physician), and increased the propofol to
12 39.3 mcg/kg/min.

13 At 10 pm the nurse documented a Ramsay score of three (the level
14 ordered by the physician) but increased the propofol to 42.75 mcg/kg/min; At midnight
15 the nurse documented a Ramsay score of four (more sedate than ordered by the
16 physician), but increased the propofol to 44.5 mcg/kg/min. The infusion remained at
17 44.5 mcg/kg/min the rest of the night shift (until 7 a.m.). No additional Ramsay scores
18 were documented.

19 On August 23, 2009:

20 7 a.m., increased to 51.4 mcg/kg/min, no Ramsay score was
21 documented;
22 8 a.m., increased to 63.8 mcg/kg/min, no Ramsay score was
23 documented;
24 9 a.m., increased to 99 mcg/kg/min, no Ramsay score was
25 documented;
26 10 a.m. and 11 a.m., decreased to 63.8 mcg/kg/min, no
27 Ramsay score was documented;
28 12 noon, increased to 70.9 mcg/kg/min, no Ramsay score
29 was documented;
30 the propofol continued to infuse at 70.9 mcg/kg/min until 7
31 a.m. (19 hours). No Ramsay score was documented.

32 During an interview with the ICU Charge Nurse on August 27, 2009, at 9:37
33 a.m., the Charge Nurse stated they titrated propofol infusions according to the Ramsay
34 scale. She stated if the nurses needed a reference when they were assessing their

1 patients, the scale was on the physician order form. The Medication Drip Titration Order
2 form was reviewed on August 27, 2009. The form indicated the Ramsay scale was
3 abbreviated as follows:

4 (a) SWHC score of four - asleep with brisk response to light
5 stimulation. Ramsay score of four - exhibits brisk response
6 to light glabellar (between the eyelids) tap or loud auditory
7 stimulus.

8 (b) SWHC score of five - asleep without response to light
9 stimulation. Ramsay score of five - exhibits a sluggish
10 response to light glabellar tap or loud auditory stimulus.
11 During an interview with the ICU Director on August 27,
12 2009, at 10:15 a.m., the director stated the facility did a ,
13 "read and sign," to educate the nurses on the use of the
14 Ramsay scale. She stated all of the ICU nurses received a
15 packet of information regarding the Ramsay scale, and they
16 had to read the information and sign a sign in sheet. The
17 director stated the facility did not validate the nurses'
18 understanding of the information. She stated, "if they have
19 questions, they ask."

20 The "read and sign" packet was reviewed on August 27, 2009. The packet
21 had a cover page directing the nurses to document a Ramsay score with every
22 adjustment of propofol. The page included a sample Ramsay scale (the same
23 abbreviated scale that was on the physician's order form).

24 During a review of Patient 302's medical record on August 27, 2009, a note
25 from the PT evaluator dated August 27, 2009, between 10:05 and 10:50 a.m., indicated
26 the patient had, "extreme," pain and the PT had alerted the nurse to this fact. During an
27 interview with RN P on August 27, 2009, at 12:30 p.m., she stated the PT had informed
her a couple of hours earlier that Patient 302 was in pain. When asked if she had
subsequently re-evaluated the patient to assess his pain, RN P stated she had not.
When asked if Patient 301 received the Norco (a pain medication) he had available
under his doctor's orders, she stated Patient 302 received a dose at 4:30 a.m., but he
had not been given the 10:30 a.m. dose of Norco.

During an interview with the MS Manager on August 27, 2009, at 12:35
p.m., she stated Patient 302's pain should have been reassessed and treated in

1 accordance with the facility policy. The facility policy titled, "Pain Management", revised
2 2/09, was reviewed on August 27, 2009. Page two of the policy indicated pain
3 management should be aggressive as well as progressive, starting with the most
4 effective immediate treatments. Page three indicated the staff was to, "Reassess
5 patients at regular intervals such as:...With each new report of pain."

6 At RSMC, on 1/12/10 at 10:00 a.m., review of Patient 70's medical record
7 revealed an order for insulin intravenous infusion per hospital approved protocol. On
8 1/11/10 at 7:00 a.m., the insulin infusion was increased from algorithm 2 to algorithm 3.
9 According to the "ICU-PCU DKA Insulin Drip Protocol," there is an order that states,
10 "Move up to the next higher algorithm if the BS (blood sugar) does not decrease by 60
11 mg/dl (milligrams/deciliter) x 2 hours." When asked how to interpret this statement, E56
12 stated she would have to clarify the statement with a physician because it was
13 incomplete and didn't provide a clear understanding of what to do. When asked the
14 same question, E57 stated she would move up to the next algorithm which was a higher
15 dose. When E57 was asked if the blood sugar was in goal range but did not decrease
16 60 mg/dl after 2 hours would she increase to the next algorithm which would put the
17 patient in jeopardy of experiencing a low blood sugar reaction, her reply was "no" and
18 she stated," This statement was unclear and I would need to clarify the order."
19 According to the two nurses interviewed, clarification was needed to accurately interpret,
20 and evaluate orders of this protocol.

21 The "ICU-PCU DKA Insulin Drip Protocol was approved by the Pharmacy
22 and Therapeutics Committee in May of 2007. This protocol had been in use for over 2 ½
23 years and E56 and 57 were unable to interpret part of the protocol that if instituted as
24 directed, could lead to severe hypoglycemic (very low blood sugars) effects including
25 seizure, coma, and death.

26 At RSMC, on 1/12/10 at 10:23 a.m., review of Patient 70's medical record
27 revealed a dose of insulin administered on 1/12/10 at 3:00 a.m.. This dose was based

1 on the protocol entitled, "ICU-PCU DKA Insulin Drip Protocol" which called for blood
2 sugar levels to be drawn hourly. The dose of insulin at 3:00 a.m. was charted as 5 units
3 administered however no blood sugar was documented as being drawn at that time.
4 Without a documented blood sugar at 3:00 a.m., the dose of 5 units of insulin did not
5 follow the protocol as ordered. The blood sugar at 4:00 a.m., increased from 148 mg/dl
6 at 2:00 a.m. to 170 mg/dl at 4:00 a.m. which was above the desired goal.

7 At RSMC, on 1/14/10 at 3:24 p.m., review of Patient 19's medical record
8 revealed he was admitted to the hospital with a severe ankle wound. Fortaz 1 gram
9 (antibiotic medication) was ordered intravenously every 8 hours on 1/8/10 at 3:40 p.m.
10 The dose was not given until 6:00 a.m. on 1/9/10 (over 14 hours after the medication
11 was ordered). E59, who was unable to find any earlier dose of Fortaz documented in the
12 chart as administered replied, "I can't explain it."

13 At IVMC, on 1/15 /10 at 3:30 p.m., review of Patient 257's medical record
14 revealed he was admitted to the hospital with the diagnosis of pneumonia. Rocephin 1
15 gram (antibiotic medication) was ordered intravenously one time on 1/2/10 at 9:50 a.m..
16 Review of the Pyxis withdrawal report shows the medication was removed at 10:04 a.m.
17 but was never documented as administered. E15 stated the medication should have
18 been given after the blood cultures were drawn.

19 At RSMC, on 1/15/10 at 9:00 a.m., review of Patient 304's medical record
20 revealed he was admitted on 1/11/10 with shortness of breath and an exacerbation of
21 congestive heart failure. Levaquin 500 milligrams (antibiotic medication) was ordered
22 intravenously every 24 hours on 1/11/10 at 10:50 a.m.. The dose was not given until 9:30
23 p.m. on 1/11/10 (over 10 ½ hours after the medication was ordered). M49 was asked if
24 she could explain why the dose was not administered even though it was located on the
25 nursing unit in their Pyxis Medstation which makes the medication readily available. M49
26 stated the patient was transferred from the ED to the Medical-Surgical floor, which she
27 was the manager of, at 4:00 p.m.. She had no explanation why the medication was not

1 given until 9:30 p.m.. When interviewed on 1/15/10 at approximately 3:00 p.m., the
2 Administrative Director for Quality Outcomes stated that the quality review for antibiotic
3 administration was to assure that antibiotics were administered within six hours.

4 According to the hospitals policy and procedure entitled, "Intravenous
5 Therapy: Medications given intravenously by a Registered Nurse," antibiotics need to be
6 administered within two hours of the physician's order to prevent or treat an infection.

7 By not administering the medication within this 2 hour time slot and leaving
8 the infection untreated, patients were at risk of an elevated fever and spread of the
9 infection.

10 At RSMC, on 1/13/10 at 4:29 p.m., review of Patient 304's medical record
11 revealed an order to administer Lasix and Aldactone (blood pressure medications) "today
12 at 12:30 p.m.." The dose of Lasix was 40 milligrams by intravenous route (in the vein)
13 and Aldactone 12.5 milligrams by mouth. During an interview with E58, she stated that
14 she decided to hold these two medications because Patient 304's blood pressure was
15 98/61 mmHg. (The mmHg is millimeters of mercury-the units used to measure blood
16 pressure). When asked if there was a physician order to hold these medications based
17 on blood pressure parameters, E58 stated there wasn't. She stated she holds blood
18 pressure medications if the systolic blood pressure (top number) is below 100 mmHg
19 and may hold the medications if the systolic blood pressure is between 100 – 110
20 mmHg. E58 held two blood pressure medications and made this decision on her own
21 and not in accordance with the orders of the physician or hospital policies.

22 On 1/14/10 at 9:13 a.m. at the IVMC, E105 passed medications including a
23 Ramipril 5 mg tablet (used to treat high blood pressure) to Patient 256. A review of
24 Patient 256's medical record at 9:46 a.m. on 1/14/10 indicated a physician had written an
25 order on 1/12/10 to hold the Ramipril for systolic (top number) blood pressure less than
26 110 mmHg. E105 had not measured Patient 256's blood pressure before she
27 administered the Ramipril. During an interview of E105 at this time, she stated she was

1 not aware Ramipril was to be held for a systolic blood pressure of less than 110 mm of
2 Hg. She pointed out that this information did not appear on Patient 256's MAR (used by
3 nurses to accurately medicate their patients and to document the date and time a dose
4 of medication was administered) and that the Patient 256's systolic blood pressure had
5 been measured at 168 mm of Hg that morning at 8:30 a.m. but she stated she did not
6 take that information into account when medicating the patient.

7 A review of the 1/14/10 MAR at 9:55 a.m. indicated that the hold
8 parameters were not printed on the Ramipril entry on this document, which nursing staff
9 depend on to accurately medicate their patients. During an interview of M32 on 1/14/10
10 at 10:19 a.m., he stated that the MARs were printed on the nursing units at 11:00 p.m.
11 daily using data from the pharmacy computerized patient medication profiles. He stated
12 that the pharmacist who entered the order should have entered the hold parameters
13 which would then have printed out on the MAR. He stated that if nurses detected an
14 error on an MAR they were to correct the error by hand on the MAR and fax a copy of
15 the corrected MAR to the pharmacy so that the pharmacy staff could correct the error in
16 the computerized patient medication profile.

17 On 1/14/10 at 10:29 a.m. during an interview of M30, he stated that there
18 was a 12 hour and a 24 hour check of the accuracy of the MARs by nursing staff. He
19 stated that the 24 hour check would have been done after midnight by the night shift
20 (after midnight on 1/13/10 for this order) and that the nurse should have hand written in
21 the correction on the 1/13/10 MAR. He stated the nurse missed the error in the
22 pharmacy order entry.

23 At RSMC, on 1/13/10 at 4:29 p.m., review of Patient 304's medical record
24 revealed a 1/12/10 order written for Protonix 40 milligrams (medication to treat stomach
25 pain). Protonix was discontinued and changed to Prilosec 40 milligrams without a
26 physician's order. Prilosec was administered on 1/13/10 and charted on the Medication
27 Administration Record (MAR) as administered at 12:15 p.m.. When M32 was asked if he

1 could locate an order in the chart for Prilosec, he stated he couldn't. The hospital
2 approved an "Automatic Therapeutic Substitution" protocol which was last revised in
3 8/03. A review of this protocol revealed that there was an automatic substitution of
4 Prilosec for Protonix but not Protonix for Prilosec. As such, substituting Protonix for
5 Prilosec required an order in the chart making this change. There was no order per
6 protocol or by Patient 304's physician to execute this change.

7 Failing to administer medications as prescribed by the patient's physician
8 constitutes conduct inimical to the public health, morals, welfare, or safety of the people
9 of the State of California in the maintenance and operation of the premises or services
10 for which the license is issued and is also a violation of title 22 CCR sections 70263(g)(2)
11 which states:

12 "All medications and treatments shall be administered as
13 ordered."

14 **XIX.**

15 **RESPONDENT NURSING STAFF DID NOT CONSISTENTLY
16 MONITOR THE BLOOD PRESSURE OF PATIENTS PLACING
17 THEM AT RISK OF INJURY OR DEATH**

18 On 1/11/10 at 9:15a.m., Patient 66's medical record was reviewed. The
19 patient was admitted to the RSMC campus Telemetry Unit on 1/9/10. The patient had
20 multiple diagnoses including a history of hypertension (high blood pressure). The initial
21 B/P reading was taken at 1:30 a.m. and was recorded as 82/45 (below normal) with the
22 patient complaining of weakness. There was no documentation the physician was
23 notified of the low blood pressure. The next blood pressure was not taken until 0400 and
24 was 107/55. When the low B/P reading was reviewed with M50, an RN, she stated she
25 would have taken another blood pressure sooner - within 15 minutes. Further review of
26 Patient 66's medical record showed the patient had another episode of low blood
27 pressure in the 80s on 1/10/10 and the rapid response team was called.

28 ///

29 ///

1 Review of the RSMC "Structure Standards-Med/Surg/Tele" showed that
2 vital signs are to be taken every four hours and could be monitored more frequently if
3 necessary.

4 Failure to monitor the blood pressure of patients could potentially result in
5 serious injury or death and constitutes conduct inimical to the public health, morals,
6 welfare or safety of the people of the State of California in the maintenance and
7 operation of the premises or services for which the license is issued and is also a
8 violation of title 22 CCR 70213 (a) which requires that:

9 "(a) Written policies and procedures for patient care shall be
10 developed, maintained and implemented by the nursing
11 service."

11 **XX.**

12 **INTRAVENOUS MEDICATIONS WERE NOT PROPERLY LABELED**
13 **POTENTIALLY RESULTING IN UTILIZATION OF MEDICATIONS**
14 **BEYOND THEIR EFFECTIVENESS**

15 Review of the hospital P&P for the IVMC and RSMC campuses entitled IV
16 Certification and Administration For Licensed Nurses, revision date 11/07, required that
17 all peripheral IVs be labeled with the date and initials of the nurse initiating the IV.
18 Further review of the policy also required that all IV solutions be changed every 48
19 hours, if they did not contain additives. IV solutions containing additives are required to
20 be changed every 24 hours, if prepared by appropriate hospital staff. Manufactured pre-
21 mixed IV solutions are required to be changed equal to or less than every 48 hours.

22 On 1/12/10 at 10:00 a.m., during a tour of the 2 West medical/surgical unit
23 at the IVMC campus with M29, it was found that IV medication bags in rooms 251, 253,
24 259, and 252 did not have labels to show the date, time, and signature to show when the
25 IV medication bags were hung. When M29 was asked why some IV medication bags
26 were labeled with date, time, and signature and others were not, she was not able to
27 answer and deferred the question to E32. E32 stated that IV bags were usually labeled
when hung.

1 On 1/12/10 at 11:00 a.m., during a tour of the 2 Central medical/surgical
2 unit at the IVMC campus with E30, IV bags were found unlabeled in rooms 235 and 221.

3 On 1/12/10 at 12:00 p.m., during a tour of the 2 East medical/surgical unit
4 at the IVMC campus with M30, IV bags in rooms 205, 206, 207, and 208 were not
5 labeled. When M30 was asked about the unlabeled IV bags, he stated that he was not
6 sure what the usual practice was and believed the nurses usually documented in the
7 MAR the time and date of when IV medications were hung.

8 Failure to label intravenous medications could potentially result in utilization
9 of medications beyond their effectiveness and constitutes conduct inimical to the public
10 health, morals, welfare or safety of the people of the State of California in the
11 maintenance and operation of the premises or services for which the license is issued.

12 This conduct is also a violation of title 22 CCR sections 70263(g)(2), 70215
13 and 70213. Pursuant to section 70263(g)(2):

14 "All medications and treatments shall be administered as
15 ordered."

16 Pursuant to section 70215(c):

17 "The nursing plan for the patient's care shall be discussed
18 with and developed as a result of coordination when
19 appropriate with staff of other disciplines involved in the care
20 of the patient."

21 Pursuant to section 70213:

22 "(a) Written policies and procedures for patient care shall be
23 developed, maintained and implemented by the nursing
24 service."

25 XXI.

26 PATIENTS WERE SENT IMMEDIATELY TO ICU AFTER SURGICAL 27 PROCEDURES TO BE MONITORED BY STAFF WHO WERE NOT PROPERLY TRAINED IN POST-OPERATIVE RECOVERY

During an interview with ICU RN 1 at IVMC on October 5, 2007, at 9:32
a.m., the RN stated she received patients from the OR immediately following surgery,
and monitored the patients during their recovery from anesthesia.

1 In order to properly monitor a patient, a registered nurse must assign the
2 nursing care of each patient to other nursing personnel in accordance with the patient's
3 needs and the specialized qualifications and competence of the nursing staff available.
4 A potentially life threatening condition which can occur following anesthesia is malignant
5 hyperthermia. Review of documents from a class done by the anesthesiologist (located
6 with the PACU orientation and competency information) stated:

7 "Though malignant hyperthermia most frequently occurs in
8 the OR...it can develop outside of the OR...after a triggering
9 agent is given. That is why it is crucial that nurses who work
in areas like ICU...know how to recognize the signs of this
disorder and initiate early treatment."

10 RN 1 stated she did not know what an Aldrete Score (a score used to
11 determine how much recovery from anesthesia has occurred) was. RN 1 stated she did
12 not know what malignant hyperthermia was, or what medication was used to treat it.

13 During an interview with ICU CN 1 on October 5, 2007, at 9:39 a.m., the
14 ICU CN stated patients came directly back to the ICU from surgery if they were on a
15 ventilator (machine used to aid in breathing) or if they had a neurosurgical procedure
16 done. ICU CN 1 stated she did not remember seeing a video on malignant hyperthermia,
17 but, "I believe there was something about that in skills day."

18 ICU CN 1 stated she did not know what the treatment for malignant
19 hyperthermia was, but she would get the medication from the pharmacy (the medication
20 was located in the PACU). ICU CN 1 stated she did not know what an Aldrete score was.

21 During an interview with ICU RN 2 on October 5, 2007, at 9:45 a.m., ICU
22 RN 2 stated she received neurosurgery patients immediately from surgery, and she
23 monitored the patient for recovery from anesthesia. The RN stated she was trained to
24 recover patients by an experienced ICU nurse.

25 The RN stated she did not know what an Aldrete score was. The RN
26 stated she had heard of malignant hyperthermia, but she did not know what medication
27 was used for its treatment, where to get the medication, or how to use the medication.

1 During a review of orientation and competency information on October 5,
2 2007, at 12:30 p.m., it was noted the ICU documents did not contain information on
3 recovering patients from anesthesia. The orientation and competency verification done
4 by the nurses in PACU included location and use of the malignant hyperthermia cart,
5 documentation requirements for the PACU, knowledge of medications specific to the
6 PACU (including dantrolene used for malignant hyperthermia), and a specific section on
7 the causes, signs and symptoms, and treatment of malignant hyperthermia. The
8 orientation and competency verification done by the ICU nurses did not contain this
9 information.

10 This conduct constitutes conduct inimical to the public health, morals,
11 welfare, or safety of the people of the State of California in the maintenance and
12 operation of the premises or services for which the license is issued. This conduct is
13 also a violation of title 22 CCR section 70214(a)(1) and 70213. Section 70214(a)(1)
14 requires that:

15 "All patient care staff shall receive and complete orientation
16 to their assigned patient care unit before receiving patient
care assignments."

17 Pursuant to 22 CCR 70213:

18 (c) Policies and procedures which contain competency
19 standards for staff performance in the delivery of patient care
20 shall be established, implemented, and updated as needed
for each nursing unit..."

21 XXII.

22 **MEDICATION CARTS AT BOTH HOSPITALS FAILED TO CONTAIN MEDICATIONS 23 DOCUMENTED BY HOSPITAL POLICY AS NECESSARY FOR EMERGENCIES**

24 On 1/12/10 at 9:36 a.m. a review of the policy and procedure entitled
25 Malignant Hyperthermia (issued 4/97 and last revised 10/09) indicated that the content
26 list contained in Respondent's policy did not match the content list contained in the
27 medication tray in the MH Carts on both the RSMC and the IVMC MH Carts. Inspection

1 of both of these supplies on 1/11/10 at 3:17 p.m. at RSMC and on 1/12/10 at 2:42 p.m. at
2 IVMC indicated that the medication tray contents on both of these carts matched the
3 content list found inside these trays and that both content lists were identical to each
4 other. The policy content list documented the supply contained six vials of procainamide
5 (used to treat dangerous irregular heart rhythms) but this was not in the medication tray.
6 The policy content list documented that the medication tray contained two 40 mg vials of
7 furosemide (used to increase urine flow in acutely failing kidneys) while the tray actually
8 contained four such vials.

9 Failing to stock the emergency medication carts as specified by
10 Respondent's policies and procedures constitutes conduct inimical to the public health,
11 morals, welfare, or safety of the people of the State of California in the maintenance and
12 operation of the premises or services for which the license is issued.

13 XXIII.

14 **LABOR AND DELIVERY PATIENTS AT RSMC WERE AT RISK OF BURNS** 15 **OR DEATH DUE TO FAILURE OF RESPONDENT TO ENSURE THAT THE** 16 **HUMIDITY BE MAINTAINED AT A PROPER LEVEL**

17 Respondents' policies and procedures provide as follows:

18 "Temperature/Humidity Monitoring, Peri-Op" states as follows:

- 19 a. the purpose of the policy was to monitor the temperature and humidity levels in the perioperative areas, as both were associated with principals of fire safety.
- 20 b. the expected perioperative humidity range was 35-60%;
- 21 c. a staff member would record the readings on a log each day before the beginning of the first case; and,
- 22 d. a surgical case would not begin until the humidity in the OR was in the proper range."

23 During an interview with OR RN 1 on November 4, 2009, at 1:40 p.m., the
24 RN stated low humidity created an increased risk for sparks and fire in the OR, and it
25 was, "a given for a circulator (the RN in the room during a surgical case)," who should be
26 continuously checking the humidity. The RN stated a fire risk assessment was done as
27 part of the time out procedure (taking time to verify the right procedure was being done

1 on the right patient) before the surgical case started, but it did not include the humidity
2 level.

3 During an interview with OB RN 1 on November 5, 2009, at 9 a.m., the RN
4 stated if the humidity in the OB Caesarian Section (CS) room was low, she sent a work
5 order to plant ops. She did not know why the room was used to conduct scheduled CSs
6 with the humidity being low.

7 During an interview with the OB CN on November 5, 2009, at 9:15 a.m.,
8 the CN stated low humidity in the OB CS room increased the risk of fire, and the
9 procedure would be held if the humidity was below 35%.

10 The facility policy titled, "Fire Risk Prevention in the Procedural/Invasive
11 and Surgical Room" stated that its purpose was to prevent risk of fires in the Operating
12 Rooms, the OB CS room, and the Procedural/Invasive room (the CCL), and referred to
13 the use of the Fire Risk Assessment Tool. The policy had the 2008 AORN guidelines
14 listed as a reference. The facility document titled, "Procedural Checklist With Fire Risk
15 Assessment," included location of the surgical procedure, use of open flow oxygen, and
16 use of a bovie as risks for fire but the document did not identify low humidity in the room
17 as a risk. The Surgery Department medical staff committee meeting minutes dated
18 September 3, 2009, were reviewed on November 4, 2009. The minutes indicated
19 temperature and humidity values were reviewed for July and August 2009, and the
20 committee discussed, "if temperature and humidity are not appropriate, the case cannot
21 start."

22 Based on a review of Respondent's policies and procedures, humidity logs,
23 labor notes, and patient anesthesia records, it was determined that the humidity in the
24 CS OR at RSMC was not within acceptable range prior to performing elective surgeries
25 on three patients during a review of a 2 day period. CSs on three of three patients
26 (Patients 7, 9 and 12). Patients 7 and 9 had elective CSs on October 26, 2009, when
27 the recorded humidity in the room was 25%, and Patient 12 had an elective CS on

1 October 28, 2009, when the recorded humidity in the room was 22%. This failed practice
2 resulted in the potential for fire in the OR, and injury to mother and baby in the OR, as
3 well as mothers and babies in the same suite as the CS OR (newborn nursery, two
4 triage rooms, and three L&D rooms).

5 Respondent also failed to ensure a safe environment for patients
6 undergoing pacemaker implants and generator (battery) changes in the CCL by failing to
7 monitor humidity levels in the room while using an alcohol based prep solution, free
8 flowing oxygen, and a bovie (an electrical cautery machine that uses heat to (1) make a
9 surgical incision by burning and destroying tissue, or (2) close small bleeding blood
10 vessels).

11 During the period of March 27 through October 24, 2009, 32 such cases
12 were performed, and the humidity in the room was not monitored. This failed practice
13 resulted in the potential for fire in the room, and burns and death in patients having the
14 procedures performed.

15 During a record review, the following was noted:

16 1) Patient 7 was scheduled on September 22, 2009 for a Cesarean
17 section on October 26, 2009. The anesthesia record indicated when the patient was
18 taken into the OR, she was placed on oxygen. The intraoperative nursing record
19 indicated a bovie was set up in the room and turned on.

20 2) Patient 9, a 31 year old female, was admitted to RSMC on October
21 26, 2009, for a repeat CS, when the recorded humidity in the CS room was 25%.. Patient
22 9 was scheduled for an October 26, 2009, CS on September 22, 2009. The labor and
23 delivery summary indicated Patient 9 was not in labor on arrival. The labor notes
24 indicated the patient presented at 3:30 p.m., for a "scheduled CS," walked to the OR at
25 4:30 p.m., and the baby was delivered at 5:03 p.m. The anesthesia record indicated the
26 patient was placed on oxygen in the OR. The intraoperative nursing record indicated a
27 bovie (an electrical cautery machine that uses heat to (1) make a surgical incision by

1 burning and destroying tissue, or (2) close small bleeding blood vessels) was set up in
2 the room and turned on. The operative report, dictated by the surgeon on October 26,
3 2009, indicated the physician used fulguration to control bleeding (an electric spark that
4 jumps from the bovie to the tissue, without the bovie actually touching the tissue, closing
5 small blood vessels).

6 3) Patient 12, a 37 year old female, was admitted to RSMC on October
7 28, 2009, for a repeat CS, when the recorded humidity in the CS room was 22%. Patient
8 12 was scheduled for an October 28, 2009, CS on October 6, 2009, the labor and
9 delivery summary indicated Patient 12 was not in labor on arrival. The labor notes
10 indicated the patient walked into the OR at 7:35 a.m. (35 minutes after the staff obtained
11 a humidity reading of 22%), and the baby was delivered at 8:01 a.m. The anesthesia
12 record indicated the patient was placed on oxygen in the OR. The intraoperative nursing
13 record indicated a bovie (an electrical cautery machine that uses heat to (1) make a
14 surgical incision by burning and destroying tissue, or (2) close small bleeding blood
15 vessels) was set up in the room and turned on. The operative report, dictated by the
16 surgeon on October 28, 2009, indicated the physician used fulguration to control
17 bleeding (an electric spark that jumps from the bovie to the tissue, without the bovie
18 actually touching the tissue, closing small blood vessels).

19 Respondent placed patients at risk of burns or death. This conduct
20 constitutes conduct inimical to the public health, morals, welfare, or safety of the people
21 of the State of California in the maintenance and operation of the premises or services
22 for which the license is issued.

23 XXIV.

24 **RESPONDENT FAILED TO ENSURE PHYSICIANS PROVIDED** 25 **TIMELY FOLLOW-UP CARE FOR NEWBORNS AT RISK OF** 26 **HYPER BILIRUBINEMIA**

27 A record review for Patient 11 was conducted on August 6, 2009. Patient
11 was born on June 4, 2009, at 4:28 a.m., at 37 6/7 weeks gestation (time developing in

1 the womb - normal 40 weeks). The Newborn Admit Flowsheet dated June 4, 2009, at
2 6:45 a.m., indicated:

- 3 a. the mother was Rh negative and the baby was AB+ (Rh
incompatible);
- 4 b. the baby's general appearance included Caput
Succedaneum (scalp swelling that extends across the
- 5 midline and over the suture lines and is associated with head
moulding);
- 6 c. the baby had bruises on the right forearm;
- 7 d. the baby was large for gestational age; and,
- 8 e. the baby was breastfed (the Well Newborn Care
Flowsheet dated June 4, 2009, at 6:30 p.m., indicated the
9 baby was breast fed for the first time at 11 hours and 45
minutes of age).

10 Because of these factors listed above, Patient 11 was at risk of developing
11 high levels of bilirubin in the blood (hyperbilirubinemia) which, in severe cases, can
12 cause seizures and brain damage.

13 It is a standard of nursing practice (which is specified in AAP guidelines), to
14 monitor and assess newborns for hyperbilirubinemia using hour specific bilirubin
15 nomograms. Specifically, the AAP guidelines state:

- 16 a. an infant with no risk factors who was discharged home at
30 hours of age should be seen by the age of 96 hours, but
17 earlier follow up should be provided for those babies who
have risk factors for developing hyperbilirubinemia;
- 18 b. the risk factors most frequently associated with
hyperbilirubinemia were breastfeeding, gestation below 38
19 weeks, jaundice in a previous sibling (brother or sister), and
jaundice noted before discharge; (Patient 11 had three of
20 these four risk factors); and,
- 21 c. phototherapy recommended for an infant at 30 hours of
age, with risk factors for developing hyperbilirubinemia, and
22 a TSB of 8.9.

23 Respondent's Policies & Procedures also stated that they would assess
24 newborns using the Hour Specific Bilirubin Nomograms which were based on standards
25 of practice.

26 Contrary to Respondent's Policies and Procedures and the AAP guidelines,
27 the nurses did not assess Patient 11 for risk factors for developing hyperbilirubinemia

1 using the The Hour Specific Bilirubin Nomogram. The nurses did not identify the Rh
2 incompatibility, bruising, delay in feeding, caput, or gestational age of <38 weeks as risk
3 factors.

4 On June 5, 2009, at 10:15 a.m. (30 hours of age), Patient 11's
5 transcutaneous bilirubin (TcB) was 9.5 mg/dl and the total serum bilirubin (TSB) was 8.9
6 mg/dl, both in the high intermediate risk zone on the Bhutani curve.

7 The Bhutani Curve contains hour specific curves of normal bilirubin values
8 within the first 5 days of life. High, intermediate, and low risk zones are designated along
9 the curves according to the risk of developing hyperbilirubinemia that will need follow-up.
10 A TcB or TSB in the Low Risk Zone or Low Intermediate Zone (40%) does not require
11 intervention. A TcB or TSB in the High Risk Zone (95%) or High Intermediate Zone
12 (75%) requires further investigation and possible intervention). (A TcB is a non invasive
13 method of screening to determine the probable level of bilirubin in the blood). (A TSB is
14 the actual level of bilirubin in the blood, determined by drawing blood and sending it to
15 the lab).

16 The Physician's Order Sheet dated June 5, 2009, at 11:20 a.m., indicated,
17 "Ok to DC home. F/U (Follow up) Mon(day) on Tue(sday) (three to four days after
18 discharge)..."

19 The Well Newborn Care Flowsheet indicated Patient 11 was discharged
20 home on Friday, June 5, 2009, at 12:50 p.m. (with multiple risk factors for developing
21 hyperbilirubinemia, the TSB in the high intermediate risk zone).

22 On August 6, 2009, at 2:26 p.m., Patient 11's records were reviewed with
23 the Nursery Manager. The Manager stated Patient 11 had risk factors for increased
24 bilirubin levels; 37 6/7 weeks gestation, bruises on the forearm, mother and baby's Rh
25 incompatibility, not feeding until approximately 12 hours after delivery, and caput
26 succedaneum. The Manager agreed that the risk factors were required to have been
27 identified on the Hour Specific Bilirubin Nomogram.

1 On August 6, 2009, at 4:40 p.m., RN 2 was interviewed. RN 2 stated TcB
2 testing was done on all babies before discharging them. RN 2 stated if risk factors for
3 increased bilirubin were identified, TcB and/or TSB testing would be conducted only if
4 the physician ordered it. RN 2 stated if a baby had increased bilirubin levels in the high
5 intermediate risk zone or high-risk zone, she would discharge the baby from the facility if
6 the physician ordered it.

7 On August 12, 2009, at 11:18 a.m., RN 3 was interviewed. RN 3 stated
8 she was the nurse who discharged Patient 11 from the facility. RN 3 stated she would
9 only conduct TcB testing if the baby was jaundiced, and only before discharging the baby
10 from the facility. RN 3 stated she would not conduct TcB testing even if risk factors were
11 identified, unless the baby was jaundiced or being discharged. RN 3 stated she
12 informed Patient 11's physician of the increased bilirubin level (high-intermediate risk
13 zone), and the physician ordered to discharge Patient 11 from the facility.

14 Title 22 CCR section 70215(b) requires:

15 "The planning and delivery of patient care shall reflect all
16 elements of the nursing process: assessment, nursing
17 diagnosis, planning, intervention, evaluation and, as
18 circumstances require, patient advocacy..."

19 And under the Nurse Practices Act:

20 "A registered nurse shall be considered to be competent
21 when he/she consistently demonstrates the ability to transfer
22 scientific knowledge from social, biological and physical
23 sciences in applying the nursing process, as follows... (6)
24 Acts as the client's advocate, as circumstances require, by
25 initiating action to improve health care or to change
26 decisions or activities which are against the interests or
27 wishes of the client, and by giving the client the opportunity
to make informed decisions about health care before it is
provided.

As such, Respondent nursing staff [R2 and R3] were required to take steps
to evaluate/assess the bilirubin level of the newborn before discharge and act as the
baby's advocate so that injury from increased bilirubin levels were not likely to occur.

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1 On August 11, 2009, Patient 11's medical record at Loma Linda University
2 Medical Center (LLMC) was reviewed. Patient 11 was admitted to LLMC on June 9,
3 2009 at 7:15 p.m. (four days after being discharged from Respondent facility). The
4 Admission history and physical dated June 9, 2009, indicated the baby was taken to her
5 primary care physician on the day of admission (June 9, 2009) for a scheduled visit. The
6 primary care physician did a TcB and the level was 15. A TSB was done, and the result
7 was 25. The parents were instructed to go to [GACH 2] NICU for further evaluation and
8 treatment of hyperbilirubinemia.

9 The Laboratory Test result dated June 9, 2009, at 7:40 p.m., stated that the
10 Total Bilirubin level was 28.2 mg/dl (normal range is 0-12.4 mg/dl) and the Direct
11 Bilirubin was 0.6 mg/dl (normal range is 0-0.4 mg/dl). Patient 11 received IV fluids, total
12 parenteral nutrition, phototherapy, and was instructed to follow-up with Inland Regional
13 Center for one year to assess neurological status and development due to identified
14 deficits.

15 During an interview with the Performance Improvement (PI) Director on
16 August 25, 2009, at 4:40 p.m., the director stated the newborn's record went to the
17 Department of Pediatrics (medical staff committee) for review on August 12, 2009.
18 According to the PI Director, the committee determined, because the baby was
19 discharged with a TSB in the high intermediate risk zone, she should have had her
20 bilirubin checked and/or been seen by her PCP the following day (24 hours later). The
21 PI Director stated the committee determined there was a deviation with the standard of
22 medical care to treat hyperbilirubinemia.

23 This conduct placed newborns at risk of developing complications
24 associated with hyperbilirubinemia and constitutes conduct inimical to the public health,
25 morals, welfare, or safety of the people of the State of California in the maintenance and
26 operation of the premises or services for which the license is issued.

27 ///

1 XXV.

2 FOR 6 OUT OF 6 PATIENT RECORDS REVIEWED, NONE
3 CONTAINED CONSENT FOR TREATMENT

4 Based on observation, interview and record review, the facility failed to
5 ensure all components of the clinical records for 6 of 6 patients receiving outpatient
6 therapy services (Patients 506, 507, 508, 509, 510 and 511) were readily accessible at
7 IVMC, resulting in the provision of services without a physician's order or a consent from
8 the patient.

9 1) A review of Patient 506's clinical record on October 4, 2007, at
10 10:56 a.m., revealed no consent for outpatient therapy treatment.

11 2) A review of Patient 507's clinical record on October 4, 2007, at 1:11
12 p.m., revealed no consent for outpatient therapy treatment. The clinical record
13 documentation indicated that the patient had received speech therapy services from
14 February 23, 2007, up to and through the date of the survey. The clinical record did not
15 contain a physician's order for speech therapy services provided between June 7, 2007
16 and August 6, 2007. During an interview with the Director of Physical Therapy on
17 October 4, 2007, at 2:27 p.m., the director acknowledged that Patient 507's clinical
18 record did not contain a physician's order for speech therapy services provided between
19 June 7 and August 6, 2007. During an interview with Speech Therapist 1 on October 4,
20 2007, at 2:35 p.m., the speech therapist acknowledged that Patient 507's clinical record
21 did not contain a physician's order for speech therapy services provided between June 7
22 and August 6, 2007.

23 3) A review of Patient 508's clinical record on October 4, 2007, at 1:55
24 P.M., revealed no consent for outpatient therapy treatment.

25 4) A review of Patient 509's clinical record on October 4, 2007, at 2:03
26 P.M., revealed no consent for outpatient therapy treatment.

27 ///

1 5) A review of Patient 510's clinical record on October 4, 2007, at 2:06
2 p.m., revealed no consent for outpatient therapy treatment. The clinical record
3 documentation indicated that the patient had received occupational therapy services
4 from December 2006, up to and through the date of the survey. The clinical record did
5 not contain physician's orders for occupational therapy services provided; December 13,
6 2006 through January 8, 2007; February 2 through April 11, 2007, and; August 11
7 through September 20, 2007.

8 During an interview with the Director of Physical Therapy on October 4,
9 2007, at 2:38 p.m., the director acknowledged that Patient 510's clinical record did not
10 contain physician's orders for occupational therapy services provided; December 13,
11 2006 through January 8, 2007; February 2 through April 11, 2007, and; August 11
12 through September 20, 2007.

13 6) A review of Patient 511's clinical record on October 4, 2007, at 2:11
14 p.m., revealed no consent for outpatient therapy treatment. The clinical record
15 documentation indicated that the patient had received occupational therapy services
16 from June 2007, up to and through the date of the survey. The clinical record did not
17 contain physician's orders for Occupational therapy services provided between
18 September 17 and October 3, 2007.

19 During an interview with the Director of Physical Therapy on October 4,
20 2007, at 2:38 p.m., the director acknowledged that Patient 511's clinical record did not
21 contain physician's orders for occupational therapy services provided between
22 September 17 and October 3, 2007.

23 During an interview with Speech Therapist 1 on October 4, 2007, at 3:04
24 p.m., the speech therapist stated that she had reviewed other clinical records for Patient
25 511, and was unable to locate a physician's order for occupational therapy services
26 provided between September 17 and October 3, 2007. During an interview with the
27 Director of Physical Therapy on October 4, 2007, at 2:38 p.m., the director

1 acknowledged that the clinical records of Patients 506, 507, 508, 509, 510 and 511 did
2 not contain signed consents for treatment. The director stated that the rehabilitation
3 services maintained separate charts for each discipline providing services to a patient.
4 The records were consolidated at the time they were scanned into the electronic medical
5 records system.

6 This conduct constitutes conduct inimical to the public health, morals,
7 welfare, or safety of the people of the State of California in the maintenance and
8 operation of the premises or services for which the license is issued. This conduct is also
9 a violation of title 22 CCR 70751(a) which states:

10 "All patient records shall be maintained in such form as to be
11 legible and readily available upon request from authorized
personnel."

12 **XXVI.**

13 **IMPROPERLY STORED FOOD PUT PATIENTS**
14 **IN JEOPARDY OF SERIOUS ILLNESS**

15 On October 2, 2007, the Department found Respondent's food storage
16 practices violated licensure requirements and constituted a situation likely to cause
17 serious injury or death to a patient. The Department found the Respondent's two food
18 storage freezers did not work properly and there was a build up of ice on the floor and
19 walls of the freezers and icicles forming on freezer shelves. Respondent admitted that it
20 had incurred several power outages in September during which the freezers were not
21 monitored for temperature fluctuations. During the power outages, facility staff moved
22 some food from one freezer to the other. Food within the freezers was observed as
23 showing signs of thawing and refreezing, and food was stored improperly such that
24 cooked and ready to eat food items were stored on shelves directly beneath raw fish and
25 sausage.

26 This conduct constitutes conduct inimical to the public health, morals,
27 welfare, or safety of the people of the State of California in the maintenance and

1 operation of the premises or services for which the license is issued. This conduct is also
2 a violation of title 22 CCR section 70273(k)(3) which provides in pertinent part:

3 All readily perishable foods or beverages capable of
4 supporting rapid and progressive growth of microorganisms
5 which can cause food infections or food intoxication shall be
6 maintained at temperatures of 7°C (45°F) or below, or at
7 60°C (140°F) or above, at all times, except during necessary
8 periods of preparation and service. Frozen food shall be
9 stored at -18°C (0°F) or below.

7 **XXVII.**

8 **RESPONDENT ALLOWED MID-LEVEL STAFF TO DIAGNOSE**
9 **PATIENTS PRIOR TO DETERMINING COMPETENCY**

10 Based on interviews and a review of professional credentials files of the
11 medical staff, the medical staff failed to enforce its own bylaws for determining
12 competency of medical staff. The bylaws state in pertinent part that concurrent and
13 retrospective review of medical records and services will be provided by each physician
14 assistant for 10 cases prior to appointment to the medical staff. This failure resulted in a
15 lack of oversight of mid-level practitioners delivering treatment and care to patients in the
16 ED.

17 Specifically, a review of six of eleven Physician Assistants (PA) were not
18 assessed as competent prior to Respondent granting them staff privileges to diagnose
19 and treat patients. Specifically, PAs 1, 2, 6, 8, 10, and 11 had not been determined to
20 be competent to perform medical screening examinations which could potentially result
21 in misdiagnoses and inappropriate treatments.

22 1) PA1 applied for medical staff privileges and was appointed to the
23 staff. The privileges for PA1 expired prior to the completion of proctoring for PA1. The
24 medical staff bylaws specify concurrent and retrospective review of medical records and
25 services provided by each PA for 10 cases, prior to appointment to the staff of the
26 hospital.

27 ///

1 2) PA2 was appointed to the medical staff of the hospital 3/10/09. A
2 review of the credentials file for PA2 and interviews with M56 revealed that proctoring
3 was completed on the evening of 1/13/10, during the survey process for the hospital.
4 According to interviews with M56 and a review of the medical staff bylaws of the hospital,
5 "proctoring shall consist of retrospective and concurrent case review."

6 3) PA6 was appointed to the medical staff of the hospital on 10/19/09.
7 A review of the credentials file for PA6 and interviews with M56 revealed that proctoring
8 was completed on the evening of 1/13/10, during the survey process for the hospital.

9 4) PA8 was appointed to the medical staff of the hospital on 4/16/07.
10 A review of the credentials file for PA8 revealed that documentation of proctoring was
11 performed for 9 cases on 4/30/08. This did not comply with the medical staff bylaws of
12 the hospital that specify 10 concurrent and retrospective case reviews. When
13 interviewed on 1/14/10 at approximately 2:40 p.m., PA 8 stated that she was unaware of
14 her "responsibility to initiate contact with her proctor when treating a patient."

15 5) The professional credentials file for PA10 revealed that proctoring
16 was performed for 10 cases on the same date. There was no written documentation that
17 the medical records review was consistent with the medical staff bylaws that require
18 concurrent and retrospective case review. The bylaws state, in pertinent part, that
19 concurrent and retrospective review of medical records and services will be provided by
20 each physician assistant for 10 cases prior to appointment to the medical staff.

21 6) On 1/11/10 at 1:50 p.m., an interview was conducted with PA 11.
22 PA 11 was sitting in a room designated as a MSE room. MSEs are patient examinations
23 done to determine if a patient has an emergency medical condition. PA 11 stated that
24 she did MSEs for ED patients and ordered tests and treatments. On 1/12/10, a review of
25 the credential file for PA 11 failed to show any written evidence of proctoring as required
26 by the Medical Staff bylaws prior to appointment by the medical staff.

27 ///

1 XXVIII.

2 **DIAGNOSIS AND TREATMENT OF PATIENTS REQUIRING**
3 **X-RAYS WERE POTENTIALLY INACCURATE DUE TO A**
4 **PATTERN OF FAILURE BY THE ED PHYSICIANS TO DOCUMENT**
5 **THEIR X-RAY INTERPRETATIONS TO RADIOLOGISTS**

6 During an interview on October 3, 2007 at 3:18 p.m. with the radiologist at
7 RSMC who reviewed x-rays for patients 412, 413 and 414, the radiologist admitted that
8 if, when no radiologist was present, and the Emergency Department (ED) physician
9 failed to document his or her preliminary findings, the (radiologists) worked on the
10 assumption that the ED physician read the x-ray correctly, so they "Didn't bother the ED
11 physician." The radiologist stated they told the ED physicians all the time to write their
12 preliminary finding, "but they get so busy, it isn't their priority."

13 During an interview with the ED Director on October 3, 2007, at 1:10 p.m.,
14 the Director stated a form was used by the physicians at IVMC, but a dictation and a
15 stamp were used at RSMC. The Director stated she does not receive letters from
16 physicians at either campus. She stated she thought the physicians mailed the letters
17 themselves. The Director stated, "Obviously, we need to change our policy."

18 A review of records in the radiology room was conducted on October 3,
19 2007, at 3:10 p.m. revealing the following;

20 1) Patient 411 was seen in the ER on October 2, 2007, and had an
21 ankle x-ray. The ED physician did not document a preliminary reading, and the
22 radiologist documented a positive diagnostic finding.

23 2) Patient 412 was seen in the ER on October 2, 2007, and had x-rays
24 of an elbow, an ankle and a wrist. The ED physician did not document a preliminary
25 finding. The radiologist had a negative finding.

26 3) Patient 413 was seen in the ER on October 2, 2007, and had an x-
27 ray done. The ED physician did not document a preliminary finding. The radiologist had a
negative finding.

1 4) Patient 414 was seen in the ER on October 2, 2007, and had a
2 chest x-ray done. The ED physician did not document a preliminary finding, and the
3 radiologist documented a positive diagnostic finding.

4 This conduct could result in patients receiving an erroneous diagnosis and
5 subsequent follow-up treatment and constitutes conduct inimical to the public health,
6 morals, welfare, or safety of the people of the State of California in the maintenance and
7 operation of the premises or services for which the license is issued. This conduct is
8 also a violation of title 22 CCR 70213(a)(2) which requires the medical staff to implement
9 their policies and procedures, and Title 22 CCR 700253(b) which requires Respondent to
10 develop and maintain radiology services as follows:

- 11 “(a) All hospitals shall maintain a diagnostic radiological
12 service.
13 (b) Written policies and procedures shall be developed and
14 maintained by the person responsible for the service in
15 consultation with other appropriate health professionals and
administration. Policies shall be approved by the governing
body. Procedures shall be approved by the administration
and medial staff where such is appropriate.”

16 The policy governing both facilities titled, "Patient Contact After Discharge
17 From the ED," was reviewed by Departmental staff on October 3, 2007. The policy stated
18 the following;

- 19 a) The ED physician would note a preliminary reading on films taken
20 when the radiologist was off duty;
21 b) The ED physician's preliminary reading would be kept with the films,
22 available for the radiologist to see what the ED physician concluded;
23 c) After the radiologist reviewed the film and rendered a final report,
24 clinically significant discrepancies would be brought to the attention of the ED physician
25 on duty;

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27 ///

1 directly adjacent to the current newborn nursery. Observation revealed one security
2 guard had been posted outside of the newborn nursery; however, if the fire doors in the
3 hall were to shut the guard was on the opposite side of the door and could not see the
4 newborn nursery and the exit doors adjacent to them. Interview with the security guard
5 outside the newborn nursery on 1//13/10 at 10:00a.m. revealed the guard had not been
6 trained on the hospital's infant security policies and procedures.

7 During an onsite tour of RSMC's ED at 10:45a.m. on 1/11/10, department
8 staff observed patients and equipment housed in the emergency exit corridors. These
9 corridors were also the emergency exit corridors for the Radiology Department, a
10 cystoscopy room and the Cardiac Catheterization Laboratory. On 1/11/10 at 3:40 p.m.,
11 M48 stated there were ED patients down the Radiology hallway 80% of the time.
12 Obstruction of these hallways was determined by the survey team to be a threat to
13 patient safety.

14 During a onsite survey on 1/12/10 it was observed that patients were being
15 relocated from the emergency department (ED) into the hallway, extending toward
16 ultrasound and the cardiac catheterization laboratory. These patient gurneys were noted
17 to obscure and block access to the fire alarm pull stations. Red lines placed on the floor
18 of the hallway, to identify the pull stations, were obscured. Interviews with nursing staff,
19 including E15 and E16, revealed that the ED nurses were unable to identify the location
20 of the fire alarm pull stations.

21 During a tour of the Wound Care Center on 1/13/10, 1/14/10 and 1/15/10,
22 the facility was observed and records for fire drills and fire sprinkler testing were
23 requested. There were penetrations in the occupancy separation wall, in the Wound
24 Care Center and there were penetrations in the walls in the Wound Care Center
25 hyperbaric room that would allow the spread of smoke or fire in a oxygen enriched
26 environment. There were no manual pull stations located in the Wound Care Center
27 building. There were no annunciation devices installed at the Wound Care Center to

1 notify patients and staff in the event of a fire. There was no audible alarm activation
2 during testing of the fire sprinkler system.

3 Failure to maintain the facility in such a manner as to protect the patients
4 and staff constitutes conduct inimical to the public health, morals, welfare or safety of the
5 people of the State of California in the maintenance and operation of the premises or
6 services for which the license is issued.

7 **XXX.**

8 **THE GOVERNING BODY MUST APPOINT A CHIEF EXECUTIVE**
9 **OFFICER WHO IS RESPONSIBLE FOR MANAGING THE HOSPITAL**

10 Based on interviews with Respondent staff, the Chief Executive Officer
11 (CEO) failed to effectively manage the facility by failing to ensure adequate staff and
12 resources were available to fulfill all managerial functions of the two hospitals.

13 Specifically, the CEO required the Respondent's department directors to be responsible
14 for the activities of their departments at both campuses, which resulted in a failure to
15 carry out their duties adequately as evidenced by the following:

16 1) During the survey, the Director of ED, the Director of Surgical
17 Services, the Director of Performance Improvement and the Infection Control
18 Coordinator stated they had difficulties overseeing their respective services at the two
19 hospitals.

20 2) The Emergency Department was toured on October 3, 2007, at 9
21 a.m. During the tour, the RN Director of Emergency Services stated, although she was a
22 40 hour a week employee, in order to keep up with the work her usual work hours were 7
23 a.m. to 8 p.m., and that it was difficult to manage departments at two campuses.

24 3) During a tour of the Surgical Suite of RSMC on October 2, 2007, at
25 2:30 p.m., the Director of Surgical Services stated, although she was a 40 hour a week
26 employee, in order to keep up with the work, her work hours were close to 12 hours a

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1 day. She stated she was not able to perform all of her duties unless she worked the extra
2 hours.

3 4) The Director of PI was interviewed on October 5, 2007, at 10:07
4 a.m. She stated she was responsible for the PI activities at the RSMC and IVMC
5 campuses. When asked about covering all PI activities at both hospitals, she stated she
6 "saw a gap in the process." She stated it was difficult to keep up with two hospitals, and
7 she had so much to do, she could only get the top priorities done. The PI Director stated
8 she was able to get the required data collected and entered, and attend meetings, but
9 she did not have time to get out to the floors in the facilities and network with the staff to
10 determine if there were QAPI issues that needed to be addressed.

11 5) The Infection Control staff (consisting of the Chief Nursing Officer
12 and the Infection Control Coordinator), were interviewed on October 5, 2007, at 1:12
13 p.m. During the interview, the ICC stated she made daily rounds, attended construction
14 rounds and meetings, and called for corrective action when needed at IVMC, but not at
15 RSMC. The ICC stated the IC activities at RSMC consisted of review of culture results.
16 The CNO stated they used to have two IC employees, but one left the facility, and they
17 had not replaced that position. The CNO stated there was no way one person could do
18 complete surveillance at both campuses, so the IC Coordinator was doing, "only the
19 essentials," at RSMC.

20 These actions by Respondent constitute conduct inimical to the public
21 health, morals, welfare, or safety of the people of the State of California in the
22 maintenance and operation of the premises or services for which the license is issued.

23 **XXXI.**

24 **THE GOVERNING BODY MUST ENSURE THAT THE SERVICES**
25 **PERFORMED UNDER A CONTRACT ARE PROVIDED IN A SAFE**
26 **AND EFFECTIVE MANNER**

27 The hospital's governing body (or organized group or individual who
assumes full legal authority and responsibility for operations of the hospital), medical

1 elective surgery for patients with anticipated ICU post-operative care placement were
2 scheduled. (page 7, line 13 through page 11, line 2, *Supra*)

3 3) The hospital failed to ensure compliance with infection control
4 program standards for sterilization of instruments used for surgical procedures. (Section
5 XII, *Supra*)

6 4) The hospital failed to ensure the performance of surgical services in
7 a safe and effective manner. (Sections XII, XIII, XIV (page 24 line 26 – page 26 line 4),
8 (page 26 line 25-Page 27, line 3), XVII, XXI, XXIII, *Supra*)

9 5) The hospital failed to ensure safe and effective pharmaceutical
10 services (Section XIV; page 32 line 10 – page 33 line 12, *Supra*).

11 6) The hospital failed to ensure a safe and sanitary environment for
12 patients (Sections XII, XIII, XIV, XV, XVI, XVII, XIX, XX, XXI, XXII, XXIII, XXIV, XXV,
13 XXVI, XXVII, XXVIII, XXIX, XXX, XXXI, XXXII *Supra*);

14 7) The hospital failed to ensure safe and effective rehabilitation
15 services. (Section XXV, *Supra*);

16 8) The hospital failed to enforce its own bylaws for determining
17 competency of medical staff. (Section XXVII, *Supra*); and

18 9) The hospital failed to ensure that the facility was maintained in such
19 a manner that safety and well being of the patients were assured. (Sections XXIII and
20 XXIX, *Supra*);

21 The cumulative effect of these systemic problems resulted in the failure of
22 the governing body to operate both campuses of the facility in a manner that was safe
23 and effective, and met the needs of the patients; constituting conduct inimical to the
24 public health, morals, welfare, or safety of the people of the State of California in the
25 maintenance and operation of the premises or services for which the license is issued.

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1 XXXIV.

2 **RESPONDENTS HAVE VIOLATED, AND PERMITTED**
3 **THE VIOLATION OF STATE REGULATIONS GOVERNING**
4 **THE OPERATION OF GENERAL ACUTE CARE HOSPITALS**

5 Health and Safety Code section 1294 provides that the Department may
6 revoke a general acute care hospital license for VIOLATION BY THE LICENSEE OF
7 ANY OF THE PROVISIONS OF DIVISION 2, CHAPTER 2, of the Health and Safety
8 Code, or of the rules and regulations promulgated under this chapter in the maintenance
9 and operation of general acute care hospital. For each instance set forth in Sections V
10 through XXXIII, *supra*, Respondents engaged in conduct that violated the provisions of
11 division 2, chapter 2, of the Health and Safety Code, or of the rules and regulations
12 promulgated therein in the maintenance and operation of the Hospital.

12 XXXV.

13 **RESPONDENT HAS DEMONSTRATED A PATTERN OF CONDUCT INIMICAL TO**
14 **THE HEALTH, MORALS, WELFARE, AND SAFETY OF ITS**
15 **PATIENTS**

16 Based on the actions of Respondent described in sections V through
17 XXXIII, Respondent has demonstrated a pattern of inability to comply with state laws and
18 has demonstrated a willful disregard of compliance of California state law, evidenced by
19 continued violations even after the issuance of a written Cease and Desist order by the
20 Department. As such, Respondent has continued to place patients in a position of harm.

21 Health and Safety Code section 1294 provides that the Department may
22 revoke a general acute care hospital license for conduct inimical to the public health,
23 morals, welfare, or safety of the people of the State of California in the maintenance and
24 operation of a general acute care hospital. For each instance set forth in Sections V
25 through XXXIII, *supra*, Respondents engaged in conduct inimical to the public health,
26 morals, welfare, or safety of the people of the State of California in the maintenance and
27 operation of the hospitals.

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1 XXXVI.

2 RESONDENT IS HEREBY NOTIFIED that, after hearing or conclusion of
3 these proceedings, the Complainant seeks that Respondent's license to operate Rancho
4 Springs Medical Center and Inland Valley Medical Center be revoked.

5 DATED:

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7 
8 KATHLEEN BILLINGSLEY
9 Deputy Director
10 Center for Healthcare Quality
11 Licensing and Certification
12 California Department of Public Health
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Exhibit A

License: 260000262
Effective: 11/07/2009
Expires: 11/08/2010
Licensed Capacity: 218

State of California Department of Public Health

In accordance with applicable provisions of the Health and Safety Code of California and its rules and regulations, the Department of Public Health hereby issues

this License to

Universal Health Services Of Rancho Springs, Inc.

to operate and maintain the following General Acute Care Hospital

SOUTHWEST HEALTHCARE SYSTEM - RSMC
25500 MEDICAL CENTER DRIVE
MURRIETA, CA 92562

SOUTHWEST HEALTHCARE SYSTEM
38485 INLAND VALLEY DRIVE
WILDMAR, CA 92595

Bed Classifications/Services

- 96 General Acute Care
- 10 Perinatal Services
- 7 Intensive Care
- 79 Unspecified General Acute Care

Other Approved Services

- Basic Emergency
- Cardiac Catheterization Laboratory Services
- Nuclear Medicine
- Occupational Therapy
- Outpatient Services at 25485 MEDICAL CENTER DRIVE, SUITE 110, MURRIETA
- Physical Therapy
- Respiratory Care Services
- Social Services

(Additional Information Listed on License Addendum)

Mark B. Horton, MD, MSPH

DIRECTOR

Teresita Reyes, HFES

(AUTHORIZED REP.)

Refer Complaints regarding these facilities to: The California Department of Public Health, Licensing and Certification, Riverside District Office, 625 E. Carnegie Drive, Suite 280, San Bernardino, CA 92408, (909)388-7170

POST IN A PROMINENT PLACE



MAILED
10-20-09 N
FOR VS

MAR-29-2010 10:48

P.03/03

State of California
Department of Public Health
License Addendum

License: 25000262
Effective: 11/07/2009
Expires: 11/09/2010
Licensed Capacity: 218

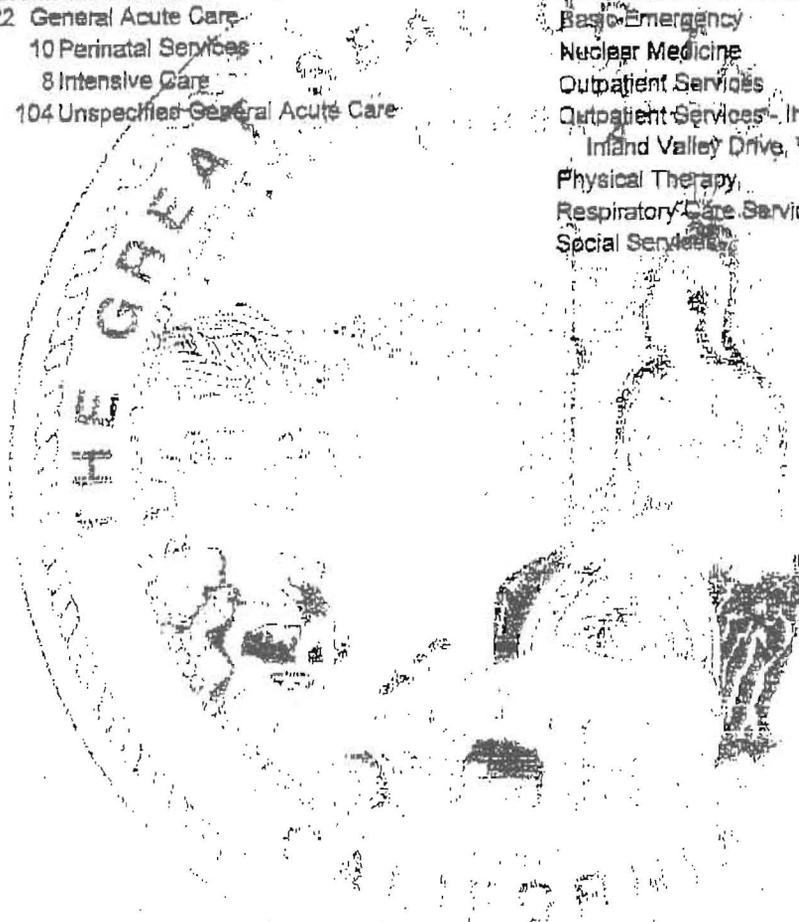
SOUTHWEST HEALTHCARE SYSTEM
36485 INLAND VALLEY DRIVE
WILDOMAR, CA, 92595

Bed Classifications/Services

- 122 General Acute Care
- 10 Perinatal Services
- 8 Intensive Care
- 104 Unspecified General Acute Care

Other Approved Services

- Basic Emergency
- Nuclear Medicine
- Outpatient Services
- Outpatient Services - Imaging Center at 36320
Inland Valley Drive, Wildomar
- Physical Therapy
- Respiratory Care Services
- Social Services



This LICENSE is not transferable and is granted solely upon the following conditions, limitations and comments:

Consolidated license

Outpatient Services are Laboratory Services at 25485 Medical Ctr. Dr., Murrieta.

Mobile Magnetic Resonance Imaging Unit at 25500 Medical Ctr. Dr., Murrieta and 36485 Inland Valley Dr., Wildomar, CA 92595. Add Outpatient Services at Center for Wound Care and Hyperbaric Medicine located at 36243 Inland Valley Drive, Suite 20, Wildomar, CA 92595.

Infusion Therapy at 25500 Medical Center Drive, Murrieta, CA 92562.

Refer Complaints regarding these facilities to: The California Department of Public Health, Licensing and Certification, Riverside District Office, 625 E. Carnegie Drive, Suite 280, San Bernardino, CA 92408, (909)358-7170

POST IN A PROMINENT PLACE

Exhibit B



MARK B HORTON, MD, MSPH
Director

State of California—Health and Human Services Agency
California Department of Public Health

Exhibit



ARNOLD SCHWARZENEGGER
Governor

June 6, 2008

Exhibit #1

Southwest Healthcare System
25500 Medical Center Drive
Murrieta, CA 92562

Dear Administrator:

The Department of Public Health, Licensing and Certification has determined that Southwest Healthcare continues to operate ICU beds outside of the designated and approved ICU in the facility (hereinafter, "satellite ICU"). On or around October 5, 2007, Southwest Healthcare was issued a verbal cease and desist order and was informed that the practice of operating a "satellite ICU" violates several state statutes and regulations. Specifically, this practice constitutes violation of Title 22, California Code of Regulations, Sections 70495(d), 70497, 70499 and 70805.

As the administrator of the facility, you are required to comply with these laws. If you fail to comply with these laws, the Department may initiate revocation of Southwest Healthcare's license as authorized under Title 22, California Code of Regulations, Section 70101(e). In addition, violations resulting in immediate jeopardy to the health or safety of a patient may result in an administrative penalty as authorized under California Health and Safety Code Section 1280.1. Further, this matter may be referred to your local district attorney as an unlawful business practice under California Business and Professions Code 17200 et seq., which may result in an injunction against the facility. Finally, the Department may notify CMS that the facility is not in compliance with certification requirements, which may lead to termination of the facility's Medicare provider agreement.

The Department will monitor the facility to ensure compliance with this order. Failure to comply with this order may result in revocation of the facility's license and/or administrative penalties as provided by law.

If you have any questions, you may contact Teresita Reyes, Health Facilities Evaluator Supervisor at (909) 388-7170.

Sincerely,

Lorraine M. Sosa
Acting District Manager
Riverside District Office

BEFORE THE
DEPARTMENT OF HEALTH CARE SERVICES
OFFICE OF ADMINISTRATIVE HEARINGS AND APPEALS

In the Matter of the Accusation Against:

SOUTHWEST HEALTHCARE SYSTEM

25500 Medical Center Dr.
Murrieta, CA 92562

License No.: 250000262

Respondent.

CDPH Case No. PCR-10-0019

NOTICE OF DEFENSE

By signing below, I acknowledge receipt of a copy of the Statement to Respondent; Accusation; Government Code sections 11507.5, 11507.6, and 11507.7 and two copies of a Notice of Defense. I hereby request a hearing in this proceeding to permit me to present my defense to the charges.

DATED: _____

Respondent

Mailing address of Respondent:

Telephone: ()

() I will not be represented by counsel.

() I will be represented by counsel.

My counsel's name, address and telephone number are:

Telephone: ()

BEFORE THE
DEPARTMENT OF HEALTH CARE SERVICES
OFFICE OF ADMINISTRATIVE HEARINGS AND APPEALS

In the Matter of the Accusation Against: SOUTHWEST HEALTHCARE SYSTEM 25500 Medical Center Dr. Murrieta, CA 92562 License No.: 250000262 Respondent.	}	CDPH Case No. PCR-10-0019 <u>NOTICE OF DEFENSE</u>
--	---	---

By signing below, I acknowledge receipt of a copy of the Statement to Respondent; Accusation; Government Code sections 11507.5, 11507.6, and 11507.7 and two copies of a Notice of Defense. I hereby request a hearing in this proceeding to permit me to present my defense to the charges.

DATED: _____

Respondent

Mailing address of Respondent:

Telephone: ()

() I will not be represented by counsel.

() I will be represented by counsel.

My counsel's name, address and telephone number are:

Telephone: ()

DECLARATION OF SERVICE BY GOLDEN STATE OVERNIGHT

In the Matter of Southwest Healthcare System
CDPH Case No. PDR-10-0019

I am employed in Sacramento County, over the age of eighteen years, and not a party to the within cause. My business address is MS 0506, P.O. Box 997377, Sacramento, CA 95899-7377.

I served a copy of the attached STATEMENT TO RESPONDENT; ACCUSATION; NOTICE OF DEFENSE; and GOVERNMENT CODE SECTIONS 11507.5, 11507.6 and 11507.7 on the following party by placing the same in an envelope affixed with a Golden State Overnight label and addressed as follows

Southwest Healthcare System
c/o C T Corporation System
818 West Seventh Street
Los Angeles, CA 90017

Said envelope was placed, on this date, in the State of California, Department of Public Health mail system to be processed, and deposited in the United States Mail at Sacramento, CA, with postage thereon fully prepaid.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 11th day of May, 2010, at Sacramento, CA.

Britney Mouer-Tozier

DECLARATION OF SERVICE BY GOLDEN STATE OVERNIGHT

In the Matter of Southwest Healthcare System
CDPH Case No. PDR-10-0019

I am employed in Sacramento County, over the age of eighteen years, and not a party to the within cause. My business address is MS 0506, P.O. Box 997377, Sacramento, CA 95899-7377.

I served a copy of the attached STATEMENT TO RESPONDENT; ACCUSATION; NOTICE OF DEFENSE; and GOVERNMENT CODE SECTIONS 11507.5, 11507.6 and 11507.7 on the following party by placing the same in an envelope affixed with a Golden State Overnight label and addressed as follows

Ken Rivers
Administrator
Southwest Healthcare System
25500 Medical Center Dr.
Murrieta, CA 92562

Said envelope was placed, on this date, in the State of California, Department of Public Health mail system to be processed, and deposited in the United States Mail at Sacramento, CA, with postage thereon fully prepaid.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 11th day of May, 2010, at Sacramento, CA.

Britney Mouer-Tozier