If continuation sheet 1 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	E CONSTRUCTION RECEIV	(X3) DATE SURVEY COMPLETED C
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E 000	Initial Comments			E 000		120 1
	ADD THE STATEM CONSTITUTED IMITHE PATIENT AND OR WERE LIKELY INJURY OR DEATH The following reflect California Departme investigation of an experiment of the constitution of the constitut	s the findings of the nt of Public Health duntity reported incident ent number: CA00176 partment:	ENT Y TO CAUSED S Iring an E. 6168		Kaiser Foundation Hose Oakland/Richmond precorrective action plan in the entity reported ever described herein to the surveyor on January 29 in order to respond to the surveyor's declaration immediate jeopardy. A in this plan of correction the actions that the Hospital to the survey January 29, 2009 in ada a status report of where hospital is with the actions that the actions that the decimal is with the actions that the actions the actions that the actions that the actions that the actions the actions the actions that the actions t	esented a related to nt DPH D, 2009 he of ttached on are spital for on dition to e the
i	T22 DIV5 CH1 ART3 Policies and Procedu (a) Written policies ar care shall be develop implemented by the number of the first Statute is not metal.	res. nd procedures for pat ed, maintained and nursing service.		264	E264, E475, E483 - Appresented in the Statem Deficiencies, tags E264 and E483 serve as the pto the findings and defias outlined in tag E485 corrective action plan to into account all finding	snent of 4, E475 preamble iciencies . The takes
(i c e	F22 DIV5 CH1 ART3- Pharmaceutical Service) A pharmacy and the committee of equivale established. The compacts one physician, or	ce General Requirem nerapeutics committe ent composition, shall mittee shall consist o	e, or a be fat	475	in E485.	

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California Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 01/29/2009 CA14000000188 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 280 W MAC ARTHUR BLVD KAISER FOUNDATION HOSPITAL OAKLAND/F OAKLAND, CA 94611 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRFFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) E 475 E 475 | Continued From page 1 of nursing service or her representative and the E485 - Pharmaceutical administrator or his representative. Services General (1) The committee shall develop written policies Requirements: and procedures for establishment of safe and effective systems for procurement, storage, distribution, dispensing and use of drugs and **Immediate Actions:** chemicals. The pharmacist in consultation with On January 27, 2009, the 1/27/09 other appropriate health professionals and Hospital conducted an administration shall be responsible for the immediate investigation development and implementations of procedures. into the events leading to Policies shall be approved by the governing body. Procedures shall be approved by the the medication error. administration and medical staff where such is o As a result of the Hospital's appropriate. independent preliminary review, Nursing and Pharmacy began a more This Statute is not met as evidenced by: intensive process of reconciling all physician orders against the Medication Administration E 483 E 483 T22 DIV5 CH1 ART3-70263(g) Pharmaceutical Service General Requirements Record (MAR) for every patient. This was initiated (g) No drugs shall be administered except by prior to the Department of licensed personnel authorized to administer Public Health visit. drugs and upon the order of a person lawfully o Pharmacy initiated their authorized to prescribe or furnish. This shall not preclude the administration of aerosol drugs by process at 10 am on respiratory therapists. The order shall include the 1/28/09 January 28, 2009 and name of the drug, the dosage and the frequency completed it by 8 am on of administration, the route of administration, if January 29, 2009. other than oral, and the date, time and signature 1/29/09 o As an independent of the prescriber or furnisher. Orders for drugs should be written or transmitted by the prescriber verification. Nursing or furnisher. Verbal orders for drugs shall be initiated their process on given only by a person lawfully authorized to 1/29/09 January 29 at 10:30 am prescribe or furnish and shall be recorded promptly in the patient's medical record, noting

the name of the person giving the verbal order

California Department of Public Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 01/29/2009 CA14000000188 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 280 W MAC ARTHUR BLVD KAISER FOUNDATION HOSPITAL OAKLAND/F OAKLAND, CA 94611 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG E 483 Continued From page 2 E 483 and completed it by and the signature of the individual receiving the midnight of that same order. The prescriber or furnisher shall day. countersign the order within 48 hours. **Temporary Actions:** This Statute is not met as evidenced by: Nursing implemented an immediate practice change that required every RN to verify the presence of a E 485 E 485 T22 DIV5 CH1 ART3-70263(g)(2) Pharmaceutical Service General Requirements valid physician's order prior to administering any (2) Medications and treatments shall be medication. This was administered as ordered. initiated as an immediate stop-gap measure to ensure This Statute is not met as evidenced by: the safety of every patient Based on observation, interviews and record in the hospital. This began reviews, the hospital failed to ensure policies and at 8:00 pm on January 28, procedures related to the medication distribution 2009 and continued and medication administration systems were 1/30/09 implemented. Failure by nursing and pharmacy through January 30, 2009. staff to implement policies and procedures o This process was put in specific to: patient identification, screening of place as a stop-gap medications for accuracy and appropriateness, measure until a more ensuring a valid physician order for all permanent, sustainable medications prior to administration, and performing comprehensive patient assessments, process could be resulted in Patient A receiving high blood implemented. The pressure medicines and other medicines without sustainable process is a physician's order. These errors directly described below. resulted in a heart attack, stroke and deep coma for Patient A. **Permanent Actions:** THIS EVENT CONSTITUTED AN IMMEDIATE Nursing and Pharmacy JEOPARDY (IJ), BECAUSE THE HOSPITAL'S Leadership: FAILURE TO IMPLEMENT WRITTEN POLICIES AND PROCEDURES TO ENSURE SAFE MEDICATION DISTRIBUTION AND

ADMINISTRATION RESULTED IN PATIENT A

California	Department of Pub	olic Health		T ·		(X3) DATE SU	RVEY	
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E 485	DEEP COMA. THU CAUSED, OR LIKE INJURY OR DEAT Findings: Patient A was a 90 Emergency Depart p.m. from home. Paltered mental stat dehydration, and not pressure. Nursing the patient had not home prior to admivital signs on 1/25/blood pressure of is 120/80). A review of admission showed the only of Patient A were a vimild pain reliever). Orders were signed and scanned from 8:35 p.m. The hospital policy IDENTIFICATION "Staff is required to identification in bosettings" when entitle hospital electro (Pyxis Connect Syverify the patient rumber during the the Pyxis system.	ROKE, HEART ATT, JS, THE ABOVE VICELY TO CAUSE, SEITH TO THE PATIENT of year-old brought to the tent (ED) on 1/25/0 attent A's diagnoses us, signs and sympto o history of high blood admission notes shou taken any medication ission to the ED. Par 1/9 at 8:50 p.m. show 119/55 (optimal blood itamin tablet and Tyle On 1/25/09, the medications order the ED to the pharm of the ED to the pharm of the inpatient and of the inpatient a	the 9 at 2:56 included oms of dowed that ons at tient A's wed a dipressure 5/09 red for enol (a dication 7:45 p.m. acy at ed that of patient butpatient lers into system were to cord entry into	E 485	o Under the sponsorship oversight of Senior Leadership (including Hospital Chief Execut Officer and the Chief Staff), Nursing and Pharmacy leaders collaborated in the enhancement of the existing medication s program to address the following: o Hospital policies procedures relate medication administration, including the Medication Administration F (MAR) verificate process, were refor accuracy and appropriateness. review ensured appropriateness review ensured policies and process and process and process and process and regulations and accrediting stan The review and	the tive of afety ae and d to Record ion viewed that cedures ith al		
	In addition, it is the professional stand	e hospital policy and lard (American Socie	a ety of			<u>.</u>		

California Department of Public Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 01/29/2009 CA14000000188 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 280 W MAC ARTHUR BLVD KAISER FOUNDATION HOSPITAL OAKLAND/F OAKLAND, CA 94611 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E 485 E 485 Continued From page 4 was completed by Hospital Systems Pharmacies www.ashp.org) for 2/15/09 February 15, 2009. pharmacists to ensure that a drug is appropriate for a patient prior to releasing it for distribution ■ Two policies and administration to the patient. The hospital "Medication policy, "KP HEALTH CONNECT MEDICATION Administration ADMINISTRATION RECORD" dated 7/23/08 Record " and states, "All orders for medications will be "Medication screened by pharmacy for accuracy and appropriateness" and the hospital policy, Management Safe "ORDERING AND TRANSCRIBING Practice" - were MEDICATIONS ELEMENTS OF A COMPLETE revised to reflect the ORDER" dated 1/09 states, "Indication for the new practice for use of routine medication orders must be available in the patient's medical records..." medication administration as At the time pharmacy staff entered medication described below. orders for Patient A, the above policies were not • The policies were followed. During an interview on 1/29/09 at 11:00 reviewed and a.m., Pharmacy Staff 6 said that hospital policies approved by the were not followed when medication orders were entered which resulted in Patient A being given Pharmacy and medications ordered for Patient B. Pharmacy Therapeutics Staff 6 acknowledged that the medication errors Committee on would have probably been avoided if two 2/18/09 February 18, 2009. identifiers had been checked in addition to the appropriateness of the medications for Patient A. The policies were She stated that Patient B's medication were not reviewed and appropriate for Patient A. She said that all the approved by the information at the time of order entry to check the Medical Executive appropriateness of the medications was available Committee on March and had she done so it would have prompted a call to the physician for clarification of the 4, 2009 3/4/09 medications ordered for Patient A. Leadership Development education The hospital allowed medications to be available for all Nursing and to Patient A without a valid physician's order. The following medications intended for Patient B were Pharmacy leaders made available in the drug distribution system to

Patient A: lisinopril 40 milligrams, amlodipine 10 milligrams, and atenolol 25 milligrams (all blood

California Department of Public Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 01/29/2009 CA14000000188 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 280 W MAC ARTHUR BLVD KAISER FOUNDATION HOSPITAL OAKLAND/F OAKLAND, CA 94611 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) E 485 E 485 Continued From page 5 pressure medications); pantoprazole 40 milligrams (a stomach ulcer medicine); and related to managing the potassium chloride 10 milliequivalents (an performance of staff electrolyte). and addressing failures to comply with standard A review of the medication administration record policies and procedures (MAR) showed that nursing staff administered to was provided. This is Patient A the medications ordered for Patient B. During an interview on 1/28/09 at 6:08 p.m., intended to create a new Registered Nurse (RN) 2 who cared for Patient A patient safety culture. on the telemetry unit, said that the admission The "Just Culture" MAR for Patient A "got lost". She ordered a training was completed second MAR and checked orders against the 3/19/09 on March 19, 2009. Pyxis system and not against the physician's orders, as required by hospital policy. Frontline managers, KFH leaders and The hospital policy, "PHYSICIANS ORDERS Professional Staff AND TRANSCRIPTION/NOTIFYING leaders will participate PROCEDURES" dated 11/06 requires nurses to review each order for accuracy and verify that the in Kaiser Permanente's orders are appropriate for that patient. The policy "Patient Safety shows, "A review of each transcribed order for University" program by accuracy and verification, and that the orders are 3rd quarter of 2009. The appropriate for that patient." program introduces and In addition, the hospital policy, "MEDICATION reinforces patient safety ADMINISTRATION PROCEDURE" dated 11/06 principles and concepts, showed that a physicians order is required before and then builds upon administration of a medication and that nurses them to help shall make appropriate observations to rule out participants learn and possible contraindications for use of medications. The policy stated, "A physician's order is required apply specific practical before any medication is administered." applications that front line leaders can use to During an interview on 1/28/09 at 6:08 p.m., staff create and sustain a was asked if the medication errors could have been avoided by following the above hospital culture of patient safety policies. RN 2 said, "Absolutely" and Nurse Manager 9 said, "Exactly."

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E 485	During an interview Pharmacy Director a professional star nurses to ensure pare appropriate for administration of earlier that director said to identified which confor Patient A. Review of Patient 1/26/09 at 9:44 autifollowing medicine milligrams, amloding pantoprazole 40 in stomach ulcers), pilliequivalents, a administered mediorder to Patient A. she said, "The merpatient matched the Pyxis." RN 1 swrong." RN 1 indiccompared the MA orders, the medical avoided. On 1/29/09 a review record dated 1/26 signs indicating a 66/47 (normal- 12 (normal- 60-100), 2-3 breaths per millier physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid Research and start in the review Physician 3 said to during a Rapid	w on 1/28/09 at 5:08 prices aid, "It is hospital production to the patients are identified in the patient prior to the each medication to the that multiple policy fail ontributed to medication. A's MAR showed that multiple policy fail ontributed to medication. A's MAR showed that m., RN 1 administered to Patient A: lisinopipine 10 milligrams, milligrams (a medicine to the medication of the medication without a physical prior and interview to the medication of the MAR. The patient said, "I did not do anyticated that if RN 2 had ation errors could have the work of the Rapid Respide wor	and and drugs ne e patient." lures were on errors t on d the oril 40 e to treat 1 1 / sician with RN 1, 8. The matched thing I mission we been onse wed vital eading of e of 47 orate of 1, ent A t 9:05 p.m.	E 485	at the department level. Pharmacy: Pharmacists were educated on the parties there use two unique, parties identified (patient name and medical record in when linking pat medication order "Pyxis Connect" re-education start 4:00 pm on 1/28/continued until a pharmacists received this eduprior to the start of into the hospital, received this eduprior to the start of shift. This was completed on Ference 128, 2009. Medication order are scanned to the Pharmacy appear "Pyxis Connect"	e re- policy n to patient rs d umber) ient s in This ted at 09 and ll ive the ame they cation of their bruary	2/28/0

California Department of Public Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 01/29/2009 CA14000000188 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 280 W MAC ARTHUR BLVD KAISER FOUNDATION HOSPITAL OAKLAND/F OAKLAND, CA 94611 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E 485 Continued From page 7 E 485 minute" and had a labile (spastically fluctuating) computer monitor and blood pressure. Physician 3 described how must be electronically Patient A was immediately intubated (a plastic linked to the patient's tube inserted into the airway to deliver life KP HealthConnect sustaining oxygen). Physician 3 said he could not rule out that the blood pressure medications (electronic medical (antihypertensive medications) administered in record) profile. error caused the severe change in Patient A. He Pharmacists are being said, "The antihypertensives certainly may have re-educated to only played a role. The medications certainly, we open one patient's KP thought, were playing a role." HealthConnect profile On 1/29/09 a review of Patient A's "Progress at any given time. This Note" dated 1/28/09 at 4:10 p.m. and signed by 1/29/09 education began on Physician 4 showed, "...patient is dying". A later 1/29/2009. As entry dated 1/28/09 at 9:45 a.m. showed, "Patient has taken a turn for the worse" ... "have not done Pharmacy staff came formal brain death testing" ... and "appears to into the hospital, they have had large M.I. (heart attack) and CVA received this education (stroke)." The same note showed, "System error prior to the start of their pharmacy for printing incorrect meds on MAR shift. This was and nurse not double checking MD orders." completed on February 2/28/09 On 1/28/09 at 6:36 p.m., Patient A was observed 28, 2009 in the Intensive Care Unit lying still in bed, on a o Medication Order Review ventilator and receiving intravenous for Clinical neosynephrine and norepinephrine (life-saving medications used to support blood pressure). In Appropriateness and an interview. RN 10 said that Patient A's "...brain Accuracy: was not responding... he's receiving maximum A Pharmacist reviews blood pressure support with medicines... the each medication order ventilator (breathing machine) is keeping him prior to it being alive." dispensed or made available through Pyxis. It is reviewed for

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E 485	Continued From parminute" and had a lablood pressure. Phe Patient A was immediate inserted into the sustaining oxygen), rule out that the blood (antihypertensive merror caused the sesaid, "The antihyper played a role. The inthought, were playing On 1/29/09 a review Note" dated 1/28/09	ge 7 abile (spastically fluctorysician 3 described lediately intubated (a per airway to deliver lift. Physician 3 said her od pressure medicatedications) administrates certainly medications certainly medications certainly medications certainly grant 4:10 p.m. and significant ensives certainly medications certainly grant 4:410 p.m. and significant ensives medications certainly grant ensives certainly grant ensives certainly medications certainly grant ensives certainly grant ensives certainly grant ensives and ensignificant ensives and ensignificant ensign	ctuating) how plastic fe could not ions ered in ent A. He ay have /, we ress ned by A later I, "Patient not done ars to VA tem error MAR rs." bbserved d, on a saving sure). In "brain ximum the	E 485	clinical appropriatent and accuracy. To reconfirm their accountability for this Pharmacists were reeducated on: The process for reviewing all medication orders for clinical appropriateness at order entry. The Pharmacist shall review the patient's medication profile for the propriateness to include: Age Weight and height (as appropriate) Diagnoses Allergies Renal function Other medication that the patient is taking	s, or at	
					 Appropriateness drug, dose, route, frequency, time 		

California Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 01/29/2009 CA14000000188 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 280 W MAC ARTHUR BLVD KAISER FOUNDATION HOSPITAL OAKLAND/F OAKLAND, CA 94611 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E 485 E 485 Continued From page 7 Potential drug minute" and had a labile (spastically fluctuating) interactions. blood pressure. Physician 3 described how contraindications Patient A was immediately intubated (a plastic and tube inserted into the airway to deliver life sustaining oxygen). Physician 3 said he could not incompatibilities rule out that the blood pressure medications • The intervention (antihypertensive medications) administered in process for unclear, error caused the severe change in Patient A. He inappropriate or said, "The antihypertensives certainly may have ambiguous orders. All played a role. The medications certainly, we thought, were playing a role." such clarifications and interventions must be On 1/29/09 a review of Patient A's "Progress discussed and verified Note" dated 1/28/09 at 4:10 p.m. and signed by directly with the Physician 4 showed, "...patient is dying". A later entry dated 1/28/09 at 9:45 a.m. showed, "Patient prescribing or has taken a turn for the worse" ... "have not done covering physician. formal brain death testing" ... and "appears to This was completed 2/28/09 have had large M.I. (heart attack) and CVA on February 28, 2009 (stroke)." The same note showed, "System error Additional Actions Taken: pharmacy for printing incorrect meds on MAR and nurse not double checking MD orders." Ongoing annual competencies for On 1/28/09 at 6:36 p.m., Patient A was observed Pharmacists will in the intensive Care Unit lying still in bed, on a include expectations ventilator and receiving intravenous regarding medication neosynephrine and norepinephrine (life-saving medications used to support blood pressure). In order review for clinical an interview, RN 10 said that Patient A's "...brain appropriateness and was not responding... he's receiving maximum accuracy, the use of two blood pressure support with medicines... the patient identifiers and ventilator (breathing machine) is keeping him opening only one alive." patient record at a time. New and temporary Pharmacist training and

California Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING CA14000000188 01/29/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 280 W MAC ARTHUR BLVD KAISER FOUNDATION HOSPITAL OAKLAND/F OAKLAND, CA 94611 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E 485 E 485 | Continued From page 7 orientation will include minute" and had a labile (spastically fluctuating) blood pressure. Physician 3 described how expectations regarding Patient A was immediately intubated (a plastic medication order tube inserted into the airway to deliver life review for clinical sustaining oxygen). Physician 3 said he could not appropriateness and rule out that the blood pressure medications accuracy, the use of two (antihypertensive medications) administered in error caused the severe change in Patient A. He patient identifiers and said. "The antihypertensives certainly may have opening only one played a role. The medications certainly, we patient record at a time. thought, were playing a role." On 1/29/09 a review of Patient A's "Progress Nursing: Note" dated 1/28/09 at 4:10 p.m. and signed by o RN Administration of Physician 4 showed, "...patient is dying". A later Medications: entry dated 1/28/09 at 9:45 a.m. showed, "Patient o The Hospital has taken a turn for the worse" ... "have not done implemented a more formal brain death testing" ... and "appears to have had large M.I. (heart attack) and CVA comprehensive (stroke)." The same note showed, "System error medication verification pharmacy for printing incorrect meds on MAR practice for all and nurse not double checking MD orders." registered nurses. The verification process On 1/28/09 at 6:36 p.m., Patient A was observed specifically matches the in the Intensive Care Unit lying still in bed, on a ventilator and receiving intravenous physician order against neosynephrine and norepinephrine (life-saving the MAR. medications used to support blood pressure). In ■ Two registered nurses an interview, RN 10 said that Patient A's "...brain verify all physician was not responding... he's receiving maximum blood pressure support with medicines... the medication orders on ventilator (breathing machine) is keeping him new admissions and alive." transfers At the change of shift, registered nurses verify all new

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	ventilator and receiv neosynephrine and i medications used to an interview, RN 10 was not responding. blood pressure supp	ing intravenous norepinephrine (life-s support blood press said that Patient A's he's receiving may out with medicines machine) is keeping	saving sure). In "brain kimum . the		to the first administration medication. The at any time due shift when a new is received. The Hospital of the "24 Hour I check" - a two process by Nu verify the new	nis occurs ring a ew order continued MAR o step crsing to	

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDED OF SHIPPITE	CA1400000018		DRESS, CITY.	STATE, ZIP CODE	0172072000	
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FORM APPROVED California Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING CA14000000188 01/29/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 280 W MAC ARTHUR BLVD KAISER FOUNDATION HOSPITAL OAKLAND/F OAKLAND, CA 94611 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) E 485 E 485 Continued From page 7 minute" and had a labile (spastically fluctuating) hand-off process blood pressure. Physician 3 described how between nurses at Patient A was immediately intubated (a plastic shift change to ensure tube inserted into the airway to deliver life verification of a valid sustaining oxygen). Physician 3 said he could not physician order with rule out that the blood pressure medications (antihypertensive medications) administered in the MAR) error caused the severe change in Patient A. He Medication said, "The antihypertensives certainly may have administration played a role. The medications certainly, we policies and thought, were playing a role." procedures, On 1/29/09 a review of Patient A's "Progress performance Note" dated 1/28/09 at 4:10 p.m. and signed by expectations, and Physician 4 showed, "...patient is dying". A later consequences of entry dated 1/28/09 at 9:45 a.m. showed, "Patient failure to comply. has taken a turn for the worse" ... "have not done formal brain death testing" ... and "appears to Training included have had large M.I. (heart attack) and CVA individual nurse (stroke)." The same note showed, "System error medication pass pharmacy for printing incorrect meds on MAR observations by a and nurse not double checking MD orders." qualified Nurse On 1/28/09 at 6:36 p.m., Patient A was observed and/or Pharmacist in the Intensive Care Unit lying still in bed, on a for all registered ventilator and receiving intravenous nurses. neosynephrine and norepinephrine (life-saving Training was completed medications used to support blood pressure). In an interview, RN 10 said that Patient A's "...brain by March 31, 2009. 3/31/09 was not responding... he's receiving maximum • For any RNs who are blood pressure support with medicines... the out on a leave of ventilator (breathing machine) is keeping him absence, training will alive." be conducted prior to the RNs being

Licensing and Certification Division

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permitted to independently

California Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING CA14000000188 01/29/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 280 W MAC ARTHUR BLVD KAISER FOUNDATION HOSPITAL OAKLAND/F OAKLAND, CA 94611 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETÉ (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E 485 E 485 | Continued From page 7 minute" and had a labile (spastically fluctuating) administer blood pressure. Physician 3 described how medications. Patient A was immediately intubated (a plastic Other Actions: tube inserted into the airway to deliver life sustaining oxygen). Physician 3 said he could not To enhance the ability rule out that the blood pressure medications for RNs to administer (antihypertensive medications) administered in medications in a safe error caused the severe change in Patient A. He environment, additional said, "The antihypertensives certainly may have Pyxis units have been played a role. The medications certainly, we thought, were playing a role." added to the nursing units and have been On 1/29/09 a review of Patient A's "Progress removed from most Note" dated 1/28/09 at 4:10 p.m. and signed by corridor locations and Physician 4 showed, "...patient is dying". A later entry dated 1/28/09 at 9:45 a.m. showed, "Patient placed in secured has taken a turn for the worse" ... "have not done rooms. This reduces formal brain death testing" ... and "appears to interruptions and have had large M.I. (heart attack) and CVA distractions thus (stroke)." The same note showed, "System error enabling the RN to pharmacy for printing incorrect meds on MAR and nurse not double checking MD orders." prepare medications for administration in a On 1/28/09 at 6:36 p.m., Patient A was observed focused, uninterrupted in the Intensive Care Unit lying still in bed, on a manner. ventilator and receiving intravenous During the 2009 annual neosynephrine and norepinephrine (life-saving medications used to support blood pressure). In competency review, an interview, RN 10 said that Patient A's "...brain medication was not responding... he's receiving maximum administration policy blood pressure support with medicines... the and procedure review ventilator (breathing machine) is keeping him will be conducted alive." accompanied by one-toone med pass observations of clinical nurse competency for

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PRINTED: 04/23/2009 FORM APPROVED California Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING C B. WING CA14000000188 01/29/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 280 W MAC ARTHUR BLVD KAISER FOUNDATION HOSPITAL OAKLAND/F OAKLAND, CA 94611 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) · E 485 E 485 Continued From page 7 minute" and had a labile (spastically fluctuating) blood pressure. Physician 3 described how all registered nurses Patient A was immediately intubated (a plastic who administer tube inserted into the airway to deliver life medications. sustaining oxygen). Physician 3 said he could not During new nurse rule out that the blood pressure medications orientation and traveler (antihypertensive medications) administered in error caused the severe change in Patient A. He nurse orientation. said, "The antihypertensives certainly may have medication played a role. The medications certainly, we administration policy thought, were playing a role." and procedure review will be conducted On 1/29/09 a review of Patient A's "Progress Note" dated 1/28/09 at 4:10 p.m. and signed by accompanied by one-to-Physician 4 showed, "...patient is dying". A later one med pass entry dated 1/28/09 at 9:45 a.m. showed, "Patient observations of clinical has taken a turn for the worse" ... "have not done nurse competency for formal brain death testing" ... and "appears to have had large M.I. (heart attack) and CVA all registered nurses (stroke)." The same note showed, "System error who administer pharmacy for printing incorrect meds on MAR medications. and nurse not double checking MD orders." o During future annual competency review, On 1/28/09 at 6:36 p.m., Patient A was observed in the Intensive Care Unit lying still in bed, on a medication ventilator and receiving intravenous administration policy neosynephrine and norepinephrine (life-saving and procedure review medications used to support blood pressure). In will be conducted for an interview, RN 10 said that Patient A's "...brain all registered nurses was not responding... he's receiving maximum blood pressure support with medicines... the who administer ventilator (breathing machine) is keeping him medications.

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alive."

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Accountable Parties: Chief Nursing Officer and Inpatient

Pharmacy Directors

California Department of Public Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING B. WING 01/29/2009 CA14000000188 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 280 W MAC ARTHUR BLVD KAISER FOUNDATION HOSPITAL OAKLAND/F OAKLAND, CA 94611 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) TAG E 485 Continued From page 7 E 485 Monitoring: minute" and had a labile (spastically fluctuating) Pharmacy: blood pressure. Physician 3 described how Patient A was immediately intubated (a plastic MAR audits Of all tube inserted into the airway to deliver life admission orders are sustaining oxygen). Physician 3 said he could not conducted by a second rule out that the blood pressure medications pharmacist to ensure (antihypertensive medications) administered in accuracy of the patient, error caused the severe change in Patient A. He said, "The antihypertensives certainly may have drug, dose, route, frequency played a role. The medications certainly, we and clinical thought, were playing a role." appropriateness. o If any issues are On 1/29/09 a review of Patient A's "Progress identified during the Note" dated 1/28/09 at 4:10 p.m. and signed by Physician 4 showed, "...patient is dying". A later audit, staff will be entry dated 1/28/09 at 9:45 a.m. showed, "Patient immediately educated. has taken a turn for the worse" ... "have not done The audit will continue formal brain death testing" ... and "appears to for two weeks of have had large M.I. (heart attack) and CVA (stroke)." The same note showed, "System error sustained compliance at pharmacy for printing incorrect meds on MAR a 90 percent accuracy and nurse not double checking MD orders." threshold for an appropriate order. After On 1/28/09 at 6:36 p.m., Patient A was observed two weeks of sustained in the Intensive Care Unit lying still in bed, on a compliance, auditing is ventilator and receiving intravenous neosynephrine and norepinephrine (life-saving done on a medications used to support blood pressure). In representative sample an interview, RN 10 said that Patient A's "...brain of orders for two was not responding... he's receiving maximum consecutive months of blood pressure support with medicines... the ventilator (breathing machine) is keeping him sustained compliance. alive." The results of the monitoring are reported to the Pharmacy and Therapeutics

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	CA1400000018 TAL OAKLAND/F TEMENT OF DEFICIENCIE' MUST BE PRECEDED BY SC IDENTIFYING INFORMA ge 7 abile (spastically flucysician 3 described hediately intubated (a periodiately intubated) de airway to deliver life. Physician 3 said hediately intubated (a periodiately intubated) de airway to deliver life. Physician 3 said hediately intubated (a periodiately intubated) de circulations and inister and interestions and inister and interestions certainly mandications certainly grant at 4:10 p.m. and significant at 4:10 p.m. and signi	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA1400000188 STREET AD 280 W M/OAKLANI TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 7 abile (spastically fluctuating) ysician 3 described how ediately intubated (a plastic e airway to deliver life Physician 3 said he could not be pressure medications edications) administered in overe change in Patient A. He tensives certainly may have medications certainly, we ga role." of Patient A's "Progress at 4:10 p.m. and signed by "patient is dying". A later at 9:45 a.m. showed, "Patient the worse" "have not done esting" and "appears to theart attack) and CVA note showed, "System error gincorrect meds on MAR e checking MD orders." .m., Patient A was observed Unit lying still in bed, on a	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA14000000188 STREET ADDRESS, CITY, S 280 W MAC ARTHUR OAKLAND, CA 94611 TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Ge 7 abile (spastically fluctuating) ysician 3 described how diately intubated (a plastic e airway to deliver life Physician 3 said he could not od pressure medications edications) administered in vere change in Patient A. He tensives certainly may have medications certainly, we g a role." of Patient A's "Progress at 4:10 p.m. and signed by "patient is dying". A later at 9:45 a.m. showed, "Patient the worse" "have not done esting" and "appears to (heart attack) and CVA note showed, "System error g incorrect meds on MAR e checking MD orders." .m., Patient A was observed Unit lying still in bed, on a ng intravenous iorepinephrine (life-saving support blood pressure). In said that Patient A's "brain he's receiving maximum ort with medicines the	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA14000000188 STREET ADDRESS, CITY, STATE, ZIP CODE 280 W MAC ARTHUR BLVD OAKLAND/ CA 94611 TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL / SC IDENTIFYING INFORMATION) Ge 7 abile (spastically fluctuating) ysician 3 described how didiately intubated (a plastic e airway to deliver life Physician 3 said he could not op pressure medications edications) administered in were change in Patient A. He tensives certainly may have nedications certainly, we g a role." of Patient A's "Progress at 4:10 p.m. and signed by "patient is dying". A later at 9:45 a.m. showed, "Patient the worse" "have not done sting" and "appears to heart attack) and CVA note showed, "System error gincorrect meds on MAR e checking MD orders." m., Patient A was observed Unit lying still in bed, on a ng intravenous norepinephrine (life-saving support blood pressure). In said that Patient A's "brain he's receiving maximum ort with medicines the machine) is keeping him	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING B. WING	

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	said "The antihype	tensives certainly ma	av have		monitoring as auditin	g	
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	thought, were playing		`.	•			
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	has taken a turn for						·
	formal brain death to			4			
	have had large M.I.	(heart attack) and C\	/A				
	(stroke)." The same	note showed, "Syst	em error				
	pharmacy for printing			•			
	and nurse not double	e checking MD order	s."			•	
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	neosynephrine and r	orepinephrine (life-s	aving				
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	was not responding			5		•	
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٠	error caused the se-	vere change in Patie	nt A. He	ļ			
	said, "The antihyper	tensives certainly ma nedications certainly	ay nave . we	į			
	thought, were playing	g a role."					1
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	Physician 4 showed entry dated 1/28/09	, "patient is dying". at 9:45 a.m. showed	A later		•		
	has taken a turn for	the worse" "have	not done	ļ	•	·	
	formal brain death to						
	have had large M.I. (stroke)." The same	note showed, "Syst	em error				
	pharmacy for printing	incorrect meds on	MAR		•		
	and nurse not double	e checking MiD order	5.				
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	in the Intensive Care ventilator and receiving		J, OII a				
	neosynephrine and r	orepinephrine (life-s	aving			•	
	medications used to an interview, RN 10	support blood press said that Patient A's	ure). in "brain		•		!
	was not responding	, he's receiving max	imum				
	blood pressure supp ventilator (breathing	ort with medicines machine) is keeping	tne him				
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(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 01/29/2009 CA14000000188 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 280 W MAC ARTHUR BLVD KAISER FOUNDATION HOSPITAL OAKLAND/F OAKLAND, CA 94611 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E 485 Continued From page 7 minute" and had a labile (spastically fluctuating) blood pressure. Physician 3 described how Patient A was immediately intubated (a plastic tube inserted into the airway to deliver life sustaining oxygen). Physician 3 said he could not rule out that the blood pressure medications (antihypertensive medications) administered in error caused the severe change in Patient A. He said, "The antihypertensives certainly may have played a role. The medications certainly, we thought, were playing a role." On 1/29/09 a review of Patient A's "Progress Note" dated 1/28/09 at 4:10 p.m. and signed by Physician 4 showed, "...patient is dying". A later entry dated 1/28/09 at 9:45 a.m. showed, "Patient has taken a turn for the worse" ... "have not done formal brain death testing" ... and "appears to have had large M.I. (heart attack) and CVA (stroke)." The same note showed, "System error pharmacy for printing incorrect meds on MAR and nurse not double checking MD orders." On 1/28/09 at 6:36 p.m., Patient A was observed in the Intensive Care Unit lying still in bed, on a ventilator and receiving intravenous neosynephrine and norepinephrine (life-saving medications used to support blood pressure). In an interview, RN 10 said that Patient A's "...brain was not responding... he's receiving maximum blood pressure support with medicines... the ventilator (breathing machine) is keeping him alive.'

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