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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION LICENSING C AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING 050492 B. WING 11/06/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CLOVIS COMMUNITY MEDICAL CENTER 2755 HERNDON AVENUE, CLOVIS, CA 93611 FRESNO COUNTY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) The statements made on the plan of The following reflects the findings of the California correction are not an admission and do not Department of Public Health during the investigation constitute agreement with the alleged of Entity Reported Event #CA 00166149. deficiencies herein. This plan of correction constitutes Administrative Penalty Number: 040005635 Community Medical Centers written credible allegation of compliance for the deficiencies Inspection was limited to the specific Entity noted. Reported Incident event investigated and does not represent the findings of a full inspection of the Corrective action plan CA 00166149 facility. T22 DIV5 CH1 ART7-70701(a) Governing Body (7) The governing body shall require that the medical staff establish controls that are designed to ensure the achievement and maintenance of high standards of professional ethical practices including California Code of Regulations Division 5, Chapter provision that all members of the medical 1, Article 7 Administration. 70701. staff be required to demonstrate their ability Governing to perform surgical and/or other procedures Body. competently and to the satisfaction of an (a) The governing body shall: appropriate committee or committees of the (7) Require that the medical staff establish controls staff, at the time of original application for that are designed to ensure the achievement and appointment to the staff and at least every maintenance of high standards of professional two years thereafter ethical practices including provision Finding: members of the medical staff be required to 1) Failure to ensure the medical staff demonstrate their ability to perform surgical and/or established controls designed to ensure the achievement of professional and ethical procedures competently and to practices when two attending physicians satisfaction of an appropriate committee QΓ failed to recognize the need to monitor the committees of the staff, at the time of original effects of warfarin to a patient for whom they application for appointment to the staff and at least shared clinical responsibility. every two years thereafter. **Governing Body** Based on staff interviews, clinical record review, How the corrective action will be administrative document review, and the Nursing accomplished, both temporarily and

Event ID:I4QB11

11/26/2008

7:26:26AM

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

2005 Drug Handbook, the hospital failed to ensure

permanently.

TITLE

(X6) DATE

Medical staff & Covering Body too

acceptable 18 141/10

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INME OF PROVIDER OR SUPPLEN  CLOVIS COMMUNITY MEDICAL CENTER  STREET ADDRESS, CITY, STATE, 2P CODE  2755 HERNDON AVENUE, CLOVIS, CA 93611 FRESNO COUNTY    CANADO   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY;  TAG    Continued From page 1   medical staff established controls that were designed to ensure the achievement and maintenance of high standards of professional ethical practices when the facility failed to:    Ensure the medical staff established controls that were designed to ensure the achievement and maintenance of professional ethical practices when two of two attending physicians (Doctor (DR) 1 and DR 2) failed to recognize the need to monitor the effects of Cournadin (generic name is warfarin - a potentially dangerous medication which would prevent the blood from clotting) being administered to a patient for whom they shared clinical responsibility. (Patient A)  2. Provide planning, implementation and evaluation of medical care when Patient A was given Cournadin (generic name is warfarin - a potentially dangerous medication which would prevent the blood from clotting) being administered to a patient for whom they shared clinical responsibility. (Patient A)  2. Provide planning, implementation and evaluation of medical care when Patient A was given Cournadin (generic name is warfarin - a potentially dangerous medication which would prevent the blood from clotting) by seven of eight Registered Nurses. (RNS) and one Licensed Vocational Nurse (LVN) without evidence of a Patinthombin (PT) and an International Normalized Ratio (INR) (PT - normal range 12.0 to 14.7 and INR normal range 0.8 to 1.2 according to the facility's laboratory reference range) tests (blood tests to determine if the dose of Cournadin was appropriate or to large. Patient A's PT was 157.1 and the INR was greater than 20) Patient A's PT was 157.1 and the INR was greater than 20) Patient He dose was appropriate or to loar give in the desired patient of	I .	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	]	ILDING	INSTRUCTION	(X3) DATE SU COMPLE	
Continued From page 1  medical staff established controls that were designed to ensure the achievement and maintenance of high standards of professional ethical practices when the facility failed to:  1. Ensure the medical staff established controls that were designed to ensure the achievement and maintenance of professional ethical practices when the facility failed to:  2. Ensure the medical staff established controls that were designed to ensure the achievement and maintenance of professional ethical practices when two of two attending physicians (Doctor (DR) 1 and DR 2) failed to recognize the need to monitor the effects of Coumadin (generic name is warfarn - a potentially dangerous medication which would prevent the blood from clotting) being administered to a patient for whom they shared clinical responsibility (Patient A)  2. Provide planning, implementation and evaluation of medical care when Patient A was given Coumadin (generic name is warfarn - a potentially dangerous medication which would prevent the blood from clotting) by seven of eight Registered Nurses (RN's) and one Licensed Vocational Nurse (LVN) without evidence of a Proffbrombin (PT) and an International Normalized Ratio (INR) (PT - normal range 12.0 to 14.7 and INR normal range 0.8 to 1.2 according to the facility's laboratory reference ranges) tests (blood tests to determine whether the dose was appropriate or too large. Patient A's PT was 1671 and the INR was greater than 20). Patient A was given the medication for eleven days without benefit of a blood test to determine whether the dose was appropriate or too large. Patient A's PT was 1671 and the INR was greater than 20). Patient A was given the medication for eleven days without benefit of a blood test to determine whether the dose was appropriate or too large. Patient A's PT was 1671 and the INR was greater than 20). Patient A was given the medication for eleven days without benefit of a blood test to determine whether the dose of Coumadin was appropriate or too large. If it was an i	CLOVIS C	OMMUNITY MEDICAL CEN	STREET AD  STREET AD  2755 HER	NDON AVENUI		, CA 93611 FRESNO COUNTY		1072000
medical staff established controls that were designed to ensure the achievement and maintenance of high standards of professional ethical practices when the facility failed to:  1. Ensure the medical staff established controls that were designed to ensure the achievement and maintenance of professional ethical practices when two of two attending physicians (Doctor (DR) 1 and DR 2) failed to recognize the need to monitor the effects of Coumadin (generic name is warfarin - a potentially dangerous medication which would prevent the blood from clotting) being administered to a patient for whom they shared clinical responsibility. (Patient A)  2. Provide planning, implementation and evaluation of medical care when Patient A was given Coumadin (generic name is warfarin - a potentially dangerous medication which would prevent the blood from clotting) by seven of eight Registered Nurses (RN's) and one Licensed Vocational Nurse (LVN) without evidence of a ProThrombin (PT) and an International Normalized Ratio (INR) (PT - normal range 120 to 14.7 and INR normal range 0.8 to 1.2 according to the facility's laboratory reference ranges) tests (blood tests to determine if the dose of Coumadin was appropriate or too large. Patient A was given the medication for eleven days without benefit of a blood test to determine whether the dose was appropriate or too large. Patient A was given the medication for eleven days an incorrect dose it would cause internal bleeding. (RN's 1, 2, 3, 4, 5, 6, 7 and LVN 1)  Event ID140811  1) Clovis Community Medical Center (CCM) Greed the Chief Nursing Officered the Chief Nursing Officered the Chief Nursing Officered the Chief Nursing Officer dether to CEO (CRC (CEO (CEO)) officer the event to Called fast track review of the event to Called fast track revi	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREFIX	,	EACH CORRECTIVE ACTION SHOULD E	BE CROSS-	COMPLETE
		medical staff estal designed to ensumaintenance of hig ethical practices when to that were designed to maintenance of profetwo of two attending DR 2) failed to recognificate of Coumadin potentially dangerous prevent the blood froto a patient for responsibility. (Patient 2. Provide planning, of medical care we Coumadin (generic nadangerous medication blood from clotting) to Nurses (RN's) and or (LVN) without evidence an International Normormal range 12.0 to 0.8 to 1.2 according reference ranges) test the dose of Coumadin Patient A's PT was 10 than 20). Patient A eleven days without determine whether the large. If it was an internal bleeding. (RN	blished controls that we are the achievement as histandards of profession the facility failed to:  dical staff established control ensure the achievement assional ethical practices who physicians (Doctor (DR) 1 as a grize the need to monitor (generic name is warfarines medication which worm clotting) being administer whom they shared clinically then Patient A was given in warfarine is warfarine a potential which would prevent to a warfarine Licensed Vocational Nurse of a ProThrombin (PT) a malized Ratio (INR) (PT 14.7 and INR normal rand to the facility's laborates (blood tests to determine was appropriate or too larges 67.1 and the INR was great was given the medication of benefit of a blood test dose was appropriate or to noorrect dose it would cause	ond onal ols on one on old ols ols on one old ols	c.	(CCMC) Chief Executive (CEO) directed the Chie Officer and Corporate P Safety Officer to report to California Departmen Health (CDPH). The evereported to CDPH on 10 CCMC CEO immediatel fast track review of the ethrough hospital Quality Safety Committee on 10 and at Clovis Medication Committee on 10/27/08.  3) CCMC CEO ensured the event was immediately reper Review on 10/10/0 CCMC CEO notified the Corporate Chief Executing Chief Operating Officers Chief Quality Officer who notified the Board of Truthe event and ensured the issues identified were incorporated into the quality officers.  The title or position of the presponsible for the correcting CCMC CEO  A description of the monito process to prevent recurrer deficiency.  Actions reviewed and complete	e Officer ef Nursing atient the event t of Public ent was 0/10/08.  by directed event Patient 0/23/08 in Safety  at the reported to 8.  ve and is and the o then stees of hat all ality inmediate  person on.  ring ince of the	10.10.08 10.23.08 10.27.08 10.10.08
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE		·			26:26AM		-	

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State-2567

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1 ' '	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL	E CONS	STRUCTION	(X3) DATE SU COMPLET		
j		050492		A. BUILDING B. WING			11/0	6/2008
	1	NTER  ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY	s		VIS, C	PROVIDER'S PLAN OF CORRECT CH CORRECTIVE ACTION SHOULD I		(X5) COMPLETE
TAG	1 '	SC IDENTIFYING INFORMA		TAG	•	ERENCED TO THE APPROPRIATE D		DATE
	Continued From page  3. Develop and improcedures for the effective systems for risk drugs such as Warfarin - a potential would prevent the blook. Findings:  1. Patient A was addror a complaint of short and prevent of the complaint of short and the stated and the normal course of the write an order to obtests which would allot the Coumadin being the stated the variet and the variet and the course of	establishment of the dispensing and Coumadin (generally dangerous medical from clotting).  mitted to the facility ortness of breath by performed by DR 1 of atrial fibrillation R 2 wrote an order egiven every day.  ist (Cl Phr) on 10/29 consulted on Patien for the duties. She patient's chart responsible physication the appropriation for monitoring the administered to alues from the che safety of Patien the provided to Patien the patient the provided to Patien the patient the pa	on 9/26/08		10 Medi:  a.   1)   2)   3)   4)	The date the immediate coraction will be accomplished 0/10/08 through 10/27/08 cal Staff  How the corrective action vaccomplished, both tempor permanently.  Physicians involved were immediate to Medical Staff through the process on 10/10/10/10/10/10/10/10/10/10/10/10/10/1	vill be rarily and mediately ugh the 10/08. The resorrance oblysicians ue to be cutive ne Board of Quality Clovis Physicians farin Hard and es narmacists atient not have The e the baseline ne d/or	10.27.08 10.10.08
	1 stated he had assume	ed care for Patient A	<u> </u>				4	
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		050492	·	B. WING		11/0	06/2008
	ROVIDER OR SUPPLIER COMMUNITY MEDICAL CEN	1	TREET ADDRESS,		CODE DVIS, CA 93611 FRESNO COU	NTY	
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	review the chart of responsibility of care 1 stated, although he Coumadin as the att it was his responsible being administered. responsibility to in studies had been ordicare and patient sa directly responsible which resulted in laboratory tests being week's time. DR responsibility to command the details for Patient A On 10/29/08 at 12:55 2 stated he had ass 9/27/08. DR 2 stated Coumadin on 9/27/0 order for the approprimonitoring of lab tests.	n 9/26/08 at 3:20 a.m ed for DR 2 to assur as DR 1 would be or unaware that DR 2 hin in his absence. receiving Coumadin med responsibility for DR 1 stated DR 2 was being administrated he did not Patient A when he for Patient A on 9/2 had not written the ending physician of illity to check the material DR 1 stated it insure appropriate dered to insure quality afety. DR 1 stated for the lack of quality the failure of a grequested for mor 1 stated he had fail municate with DR 2 wis care.  p.m., during an integrate of Patie dhe had written and the lack of the lack of quality and the had written and lack and had never we are lab tests or the ass. DR 2 stated he between the lack of the lack of patie dhe had written and lack and had never we are lab tests or the ass. DR 2 stated he between the lack of the lack of the lack of the lack of patie dhe had written and lack and had never we have the lack of	ne care of ut of town. The care of ut of town. The care of the care of did not tell istered to thoroughly the resumed 19/08. DR order for Patient A, medications was his laboratory by medical I he was hality care appropriate than a ted in his 2 regarding the care or order for written an appropriate or order for written an appropriate oriefed DR		process for Hand-Off C was developed by the Officer and approved of Clovis Facility Executiv.  The process was explained the process was explained in the process was explained in the process of 11/3/C Staff Office.  Compliance of 92% has as of 12/9/08  The Quality Director with track and monitor weel communication and continuous exponsible for the continuous exponsion exponsible for the continuous exponsion expon	Chief Quality in 10/30/08 by re Committee.  sined and a sent to Clovis 18 by Medical 18 been achieved 19 continue to 19 chief and 19 ch	11.3.08 12.9.08 ONGOIN 10.21.08
	1 and told him Paties on a daily basis whe of Patient A on 9/29/08	en DR 1 resumed res			achieved as of 12		12.9.08
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NAME OF PROVIDER OR SUPPLIER  CLOVIS COMMUNITY MEDICAL CE	STREET ADDRESS	S, CITY, STATE, ZI	P CODE DVIS, CA 93611 FRESNO COUNTY	1 1111	30/2000
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE (	BE CROSS-	(X5) COMPLETE DATE
which resulted in laboratory tests being  On 10/29/08 at 11:32 Chief Executive Of ultimately responsible staff as a means of and patient safety. of the lack of communication of the lack of the lac	for the lack of quality care a failure of the appropriate requested.  2 a.m., during an interview, the ficer (CEO) stated he was for oversight of the medical ensuring quality medical care. The CEO stated he was aware unication between DR 1 and DR in a failure of appropriate grequested for more than a EO stated he was unaware DR ghly review the chart of Patient ed responsibility of care on EO stated he had ultimate oversight of the medical staffiality of care rendered and lack		The Quality Director we to track and monitor we physician communication compliance.  d. The date the immediate compliance.  d. The date the immediate compliance.  *Peer Review submission  *Warfarin Hard Stop Proces  *Hand-Off Communication is the Monitoring  Finding:  2) Failure to provide planning, implementation and evaluation or care when patient was given ware eight nurses without evidence of determine if the dose was appropriate the dose was appropriate and the corrective action with the accomplished, both tempor permanently.	rective ed.  s letter etter f medical farin by lab tests to oriate.	0NGOIN 10.10.08 10.21.08 11.3.08 12.9.08
9/26/08 for complaint Doctor 1 (DR 1). performed by DR1 o of atrial fibrillation (re Doctor 2 (DR 2) wrot name is Coumadin medication which we clotting) 5 milligrams (re From 9/27/08 through RN 4, RN 5, and RN to Patient A. On administered warfarin	of shortness of breath by The History and Physical in 9/26/08 included a diagnosis apid heart beat). On 9/27/08, the an order for warfarin (brand - a potentially dangerous build prevent the blood from ing.) to be given every day.  10/1/08 at 9:00 p.m., RN 3, if 6 administered Warfarin 5 mg. 10/2/08 at 9:00 p.m. LVN 1 5 mg. to Patient A. On 0/4/08 at 9:00 p.m., and		<ol> <li>The Nurse Managers counurses who administered the patient.</li> <li>On 10/10/08. The Nurse I implemented a Hard Stop collaboration with the Phamanager.</li> <li>All new Warfarin orders in baseline PT/INR and CBC prior to administering the If the labs are not ordered will call the physician and orders. The pharmacy will dispense the medication of the patients.</li> </ol>	Managers Process in armacy  nust have a C recorded medication. If, the nurse obtain lab I not	10.30.08
Event ID:I4QB11	11/26/2008	7:26:26	AM		

(X6) DATE

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NAME OF PROVIDER OR SUPPLIER  CLOVIS COMMUNITY MEDICAL CEI	STREET ADDRESS	S, CITY, STATE, ZIP C	CODE FIS, CA 93611 FRESNO COUNTY	11/06/	2006
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETE DATE
mg. to Patient A. of administered warfarin 10/7/08 at 9:00 p.m., mg. to Patient A. evidence of a PT and record for 11 doses of During an interview of stated it is the administering warfarin INR before giving it.  During an interview of stated Patient A should an interview of stated Patient A should be a a should b	RN 1 administered warfarin 5 On 10/6/08 at 9:00 p.m., RN 7 on 5 mg. to Patient A. On RN 2 administered warfarin 5 There was no documented d INR test in Patient A's clinical warfarin.  In 10/29/08 at 2:40 p.m., LVN 1 responsibility of the nurse of the to check a patient's PT and con 10/29/08 at 2:55 p.m., RN 7 could have had a baseline PT and INR's before giving her depatient A did not have a PT		baseline labs obtained an reviewed.  (b) The daily dose of Warfarir administered unless a PT drawn and documented or for that day. If there is not ordered, the Nurse obtains from the physician and reviewits prior to administrat Warfarin. The Nurse contaphysician with lab results obtains a new order for Wineeded.  After 10/30/08, the Nurse the pharmacist in the ever order (PT/INR) is missing will not dispense the daily Warfarin until the PT/INR verified by Nursing. The Michael Carts are then stocked by with the daily dose of Warfarin until dose o	n is not /INR is n the MAR an INR s an order views lab ion of acts the and arfarin if  contacts nt a lab Pharmacy dose of lab is ledication Pharmacy	10.30.08 AND BMGOING
During an interview of stated it is a nurse's and INR before giving think I saw the INR before An excerpt taken Handbook contained for Coumadin: "Nurse to establish baseline therapyPT and INF for proper control same time daily. If fibrillation is 2 to 3."	the following under the listing sing Considerations-Draw blood coagulation parameters before determinations are essential Give warfarin (Coumadin) at NR range for chronic atrial A's Medication Administration		3) No Warfarin is stocked in Automated Dispensing Un CCMC beginning 10/10/08  4) Beginning 10/10/08 all Nu ICU, Telemetry and Med-seducated prior to the start shift on the Hard Stop Pro Warfarin dosing, drug-drug interactions, signs/sympto Warfarin reactions and acrequired for monitoring an pharmacist/physician notif  5) Reference provided to nur symptoms of over anti-coamelena, petechiae, microshematuria, oozing from su injuries such as blood draw sites, bleeding from the gu	rses in the Surg were of their cess, g/nutrient ms of tication. sing of agulation: acopic perficial ws, IV	0.10.08 (0.10.08 (HRU 1.3.68
Event ID:I4QB11	11/26/2008 R/SUPPLIER REPRESENTATIVE'S SIGNA		TITLE	~	6) DATE

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1		050492		B. WING	_		11/0	6/2008
	ROVIDER OR SUPPLIER COMMUNITY MEDICAL CEI	NTER	STREET ADDRESS 2755 HERNDON			93611 FRESNO COUNTY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	•	PROVIDER'S PLAN OF CORRECT H CORRECTIVE ACTION SHOULD I RENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETE DATE
	required/Coumadin Dri During an interview Chief Nursing Office the information adv required/Coumadin visible to each nurse the medication, they di	aily printout of the Drug/Nutrient ug/Drug Interaction."  on 10/29/08 at 3:0 or (CNO) stated the rising "Drug/Nutrient Drug/Drug Interaction who read the order don't act on it.  8 at 9:30 a.m., the said Pharmacist for warfarin (branch of tially dangerous meatting) into the correntries by a pharming process. The 7/08 in the medical lligrams) daily. The 8 in Patient A's medical ligrams daily. The Patient A's physicials of wrote in Patient drug-drug interactions where in Patient drug-drug interactions warfarin.  1/29/08, the Phr Medical warfarin in its his procedures.	education  00 p.m., the at although the education to education to education to emputer for macist were physician's record was CI Phr said dical record and to order A's medical on between empty, which The CI Phr policy and education to educ		6) 7)	brushing teeth and excess menstrual bleeding. Coffee emesis and nosebleeds as signs. Any of these sympt be reported to the physicial immediately.  On 10/30/08, the Pharmac Nursing Managers revised expanded the Medication Risk/High Alert policy:  (a) Medications- High Alert policy was exinclude drugs record by the Institute of Improvement (Get Started Kit: Prever from High-Alert Michael How-to Guide). The listed drugs/categoriculude:  (i) Insulin IV Infu Heparin Infus Bolus, Conce Electrolytes (Magnesium a Potassium), Neuromuscul Blocking Age Vasopressors Warfarin, chemotherap Epidurals.  The MAR was revised on to include the statement for "High Alert Med: Record of PT/INR. MAR co-signature LVN, Mid-Level Provider) education required."	e ground re also oms must an  cy and I and High  Risk/High cpanded to mmended Healthcare ting at Harm edications, ee following ories usion, sion and entrated Sodium, and lar nts, s Agents, y, and all  10/30/08 or Warfarin, laily e (RN, and patient	10.30.08 10.30.08 10.30.08
Event ID:	  4QB11		11/26/2008	7:26:2	6AM			<u> </u>
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i i	OVIDER OR SUPPLIER	NTER	STREET ADDRESS 2755 HERNDON		EIP CODE LOVIS, CA 93611 FRESNO C	COUNTY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE ACTION REFERENCED TO THE APPR	N SHOULD BE CROSS-	(X5) COMPLETE DATE
	(anticoagulants). The Medication Orders there are questions will be contacted Further, they read, concerns with the physician will be conthe patient." Listed items but patient safety Patient A received wifrom 9/27/08 until medication administrated items to the patient of adjusting patient bleeding.  On 10/29/08 at 10:48 A, Doctor (DR) 1, recommendations which medical record by overlooked it. It reviewing the recommof quality care."  Daseline INR." A bas ordered before a patient of 10/29/08 at 10:48 A and the recommof quality care."	11/2/07 listed 10 coulde warfarin or the ecrease blood e policy and procedude policy and procedude pharmacist Review and/or concerns, that to discuss these "If there are of medication present acted before administed before administed before administed arfarin, 5 mg, daily 10/7/08 according ation records (M/not document that ational Normalized 10/8/08. An INR Warfarin for the duties doses and a.m. the physician said he did not chine were written in the CI Phr. In was my responsendations and it work to the ward of the	category of clotting edures titled verad, "If the physician concerns." tuestions or cribed, the inistration to were nine for 11 days to the AR). The taclotting Ratio, had is used to tall purposes preventing for Patient of see the Patient A's the said, "I asibility" for was "a lack ald order a te which was arfarin.		Risk/High Alert p  Nursing education expanded to incle Department, PAI areas and Surges Hard Stop Proces classes were material expanded by 11  9) All new nurses the on the Warfarin I and Medications Alert policy prior medications.  10) The Medications Alert policy completed by Nursing and Fall identified drugs  (a) The Nursing Language Supervisor (or all patients on Alert medication and completes Any medication are immediate pharmacy and physician for reintervention.  (b) The Nursing Language Supervisor (or compliance for and completes Any medication are immediate pharmacy and physician for reintervention.  (c) The monitoring the Nurse Marmonthly report Safety Commic compliance under the supervisor of the supervisor of the supervisor of the supervisor of the Nurse Marmonthly report Safety Commic compliance under the supervisor of the supervisor o	on was also ude the Emergency CU, Procedural ry on the Warfarin rss. All educational andatory and /20/08  ired receive training Hard Stop process -High Risk/High to administration of  - High Risk/High bliance is monitored Pharmacy daily for rgs.  Unit Clinical designee) identifies High Risk/High ons. Unit Clinical designee) reviews r each medication s the monitoring tool. In compliance issues rely communicated to the attending eview and g tool is submitted to mager for review, mager will submit a t to Quality Patient ttee for unit	10.30- 11.20.08 ONGOIN 11.5.08 AND ONGOIN
Event ID:I	aware of the drug intera	CON WILL AMBODATO	11/26/2008	7:26:26	5AM	•	
	Y DIRECTOR'S OR PROVIDE	D/SI IDDI IED DEDDESEI			TITLE		(X6) DATE

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State-2567

1	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
	·	050492	B. WING		11/0	6/2008
	(EACH DEFICIENCY	i	DRESS, CITY, STATE,  JOON AVENUE, C  JD  PREFIX  TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROPRIES	CORRECTION SHOULD BE CROSS-	(X5) COMPLETE DATE
	Continued From page	8				
	drug interactions vareceiving.  On 10/29/08 at 12:50 order for warfarin said before ordering the dipractice to order an ill administering the first "I overlooked the needless."	t aware of the other potent with drugs Patient A w  Dp.m., DR 2, who wrote to the did not order an INR terrug. He said it was a regul NR and view the results before dose of warfarin. He state and to order INRs" and it was not getting INRs. He state ke."	he est lar re ed,	b. The title or position of responsible for the control of the form of the form of the following of the following of the following of the following of the form of the following of the form of the following of t	and Nurse emetry, Med- Department monitoring recurrence of the agers monitored ance by nurses Warfarin Hard- eginning	10.10.08
	approved by the Administration (FDA) warning. The warnin major or fatal ble database, listed the increase the effects amiodarone, acetam	ure for warfarin which wa Federal Food and Dru which contained a boxe og related the drug can caus eding. Lexicomp, a dru following drugs which ma	ed see ug g; g; ff),	10/10/08) and M risk/alert policy (10/30/08) Comp 100%.  2) Beginning 10/10/1/2009, the Phar concurrent daily bedside nurse ut Warfarin Flow SI monitoring will be 100% compliance for 3 months.	10.30.08 12.4.08 THRU 1/2000	
	agents (aspirin). Prand aspirin from propoxyphene and a 10/6/10/7 and 10/8/08.  On 10/29/08 at 4:00 g (Phr Mgr) said there	atient A received amiodaror 9/27/08 through 10/9/08 at cetaminophen on 10/2, 10/0.m., the Pharmacist Manag was no documentation Phreshysician about the order for	ne nd '3, er 1	of all High Risk/l medications for o policy until 100% is achieved for 3	ne Nursing Unit ator (or designee) High Alert compliance with compliance rate months.	11.3.08 THRU 1/2009
Event ID:I4	warfarin.  The cumulative effect the PT and INR for base	s of physician failure to ordeline use of anticoagulants	er	Manager, review Nursing Officer a Patient Safety C	and Quality	

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

TITLE

(X6) DATE

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NAME OF PROVIDER OR SUPPLIER  CLOVIS COMMUNITY MEDICAL CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  2755 HERNDON AVENUE, CLOVIS, CA 93611 FRESNO COUNTY   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  Continued From page 9  such as warfarin; pharmacist not following through with their recommendation; nurses administering warfarin without PT and INR baseline; lack of oversight by administration; and no policy and procedure for high alert-high risk use of anticoagulant: resulted in Patient A's PT being abnormally prolonged and the INR being critically abnormally prolonged and the INR being critically.  STREET ADDRESS, CITY, STATE, ZIP CODE  2755 HERNDON AVENUE, CLOVIS, CA 93611 FRESNO COUNTY     D		AN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SI COMPLE				
PRETIX (EACH DEFORENCY MUST BE PRECEDED BY FULL PRECEDITOR FOLID BE CROSS-RECONDENCY MATCH PROJULD BE CROSS-RECONDENCY MITTING MPORMATION)  Continued From page 9  such as warfarin; pharmacist not following through with their recommendation; nurses administering warfarin without PT and INR baseline; lack of oversight by administrating, and no policy and procedure for high alert-high risk use of anticoagulant; resulted in Patient As PT being abnormally prolonged and the INR being critically high. These faitures contributed to the death of Patient A, who expired on 10/8/08 after suffering a massive bleeding into her brain as indicated by her Computed Tomography Scan dated 10/8/08.  Pharmacy  a. How the corrective action will be accomplished, both temporarily and permanently.  Pharmacy  a. How the corrective action will be accomplished, both temporarily and permanently.  Pharmacy  a. How the corrective action will be accomplished, both temporarily and permanently.  Pharmacy  a. How the corrective action will be accomplished, both temporarily and permanently.  Pharmacy  a. How the corrective action will be accomplished, both temporarily and permanently.  Pharmacy  a. How the corrective action will be accomplished, both temporarily and permanently.  Pharmacy  a. How the corrective action will be accomplished, both temporarily and permanently.  Pharmacy  a. How the corrective action will be accomplished, both temporarily and permanently.  Pharmacy  a. How the corrective action will be accomplished, both temporarily and permanently.  Pharmacy  a. How the corrective action will be accomplished, both temporarily and permanently.  Pharmacy Manager counseled the dispensing pharmacist for this incident on medication orders and pharmacist recommendations directly to the physician of the first physician for a lab order if the physi						A 93611 FRESNO COUNTY	<u> </u>	0.072000
such as warfarin; pharmacist not following through with their recommendation; nurses administering warfarin without PT and IMR baseline; lack of oversight by administration; and no policy and procedure for high alert-high risk use of anticoagulant; resulted in Patient As PT being abnormally prolonged and the IMR being critically high. These failures contributed to the death of Patient A, who expired on 10/9/08 after suffering a massive bleeding into her brain as indicated by her Computed Tomography Scan dated 10/9/08.  Pharmacy Image: A low the corrective action will be accomplished, both temporarily and permanently.  1. Pharmacy Manager counseled the dispensing pharmacist for this incident on medication orders and pharmacist for this incident on the need to communicate significant clinical recommendations directly to the physician.  3. Pharmacy initiated a hard stop process for Warfarin and Idi NOT dispense to any patient (hospital wide) without verifying a baseline CBC, PT and Idi NOT dispense to applied the physician for a lab order if the physician did not 11/26/2008  Event ID:140B11 11/26/2008 7:26:26AM	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREI	FIX (EA	CH CORRECTIVE ACTION SHOULD	BE CROSS-	COMPLETE
pharmacists contacted the physician for a lab order if the physician did not  Event ID:I4QB11 11/26/2008 7:26:26AM		such as warfarin; ph with their recomme warfarin without PT oversight by admini procedure for hig anticoagulant: resulte abnormally prolonged high. These failures Patient A, who expire massive bleeding into	armacist not following throndation; nurses administed and tNR baseline; lack stration; and no policy in alert-high risk used in Patient A's PT because and the INR being critics contributed to the deathed on 10/9/08 after suffering her brain as indicated by	ering of and of eing cally of g a	Findin 3) Far policic estab for the such  Pharma. Ho accepted 1.	action will be accomplished *Nurses counseled *Hard stop process implement *No Warfarin in Pyxis *Education - Hard Stop Proce Bleeding symptoms *Education — Medications Hig Risk/High Alert Policy *Education - New Nurses *Monitoring  *Magnetic to develop and implement es and procedures for the dishment of safe and effective e dispensing and use of high as warfarin.  *Macy *We the corrective action will complished, both temporar rmanently.  Pharmacy Manager counse dispensing pharmacist for tincident on medication ord pharmacy Manager counse clinical pharmacist for this on the need to communical significant clinical recommed directly to the physician.  Pharmacy initiated a hard s process for Warfarin and d dispense to any patient (ho wide) without verifying a ba	chanted content written conten	10.10.08 10.10.08 10.10.08
						pharmacists contacted the	physician	10.30.08
		·			7:26:26AM			

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the date these documents are made available to the facility. If deficient is a process are cited an approved plan of correction is requisite to continued program participation.

State-2567

STATEMENT OF CO		(X1) PROVIDER/SUPPL IDENTIFICATION N		(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		050492		B. WING		11/0	06/2008
	ER OR SUPPLIER MUNITY MEDICAL CEI	NTER	STREET ADDRESS 2755 HERNDON		CODE DVIS, CA 93611 FRESNO COUI	NTY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLET DATE
					Warfarin to the pharmacist co physician, Wan dispensed unti	prescribe the st verified NR) and when ed the physician d/or request:  It is adjustments ab values.  Cant drug-drug  NR is above goal dispensing the expandistry patient. If the uld not reach the farin was not all a physician on-call arough the Chain of all a physician on-call arough the Chain of a physician on-call arough the Chain of a physician on-call a physician on-call arough the Chain of a physician on-call all Staff acted.  All Staff acted.  All Staff acted in a physician in the ave a lab order or a PT/INR on g Warfarin in the ave a lab order or a pharmacist did ug. The labseline labs dicable, contacted on municate and/or e adjustments ab values.  Cant drug-drug  IR is above goal	10.30.0
vent ID:I4QB11			11/26/2009	7.26.2644			<u> </u>
	CTOR'S OR PROVIDER/	SUPPLIER REPRESENT	11/26/2008 ATIVE'S SIGNATUR	7:26:26AM	TITLE	(XI	B) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the indings above are disclosable 9b days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited an approved plan of correction is equisite to continued program participation.

STATEMENT OF DEI AND PLAN OF CORF		(X1) PROVIDERA IDENTIFICAT	SUPPLIER/CLIA FION NUMBER;	(X2) MULTIPL  A. BUILDING  B. WING	E CONSTRUCTION	(X3) DATE SU COMPLET	ED
NAME OF PROVIDER	OB SUPPLIED		ETRETT ADDRE			11/0	6/2008
	NITY MEDICAL CE	NTER		SS, CITY, STATE, ZIP ON AVENUE: CLO	VIS, CA 93611 FRESNO COL	INTY	
	•				TIO, ON JOURT TREONG GOE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICI MUST BE PRECEED SC IDENTIFYING INF	ED 8Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPE	HOULD BE CROSS-	(X5) COMPLETE DATE
					pharmacist or physician, Wa dispensed un reached. The contact the pil and proceed Medical Staff Command un could be contout the pil and proceed Medical Staff Command un could be contout to the patient quality assist which monitors the response to Warfar is used collaboratin and Nursing to revithe patient's respound the patient's Warfarin Flow She the Pharmacy.  (a) The clinical pil evaluates and "Warfar in Flow patients on the daily rounds, has the bedsis complete the Sheet" from the perspective of assessment for bleeding. The reviews and of daily INR priobeing dispense pharmacist response contact the contact of the perspective of t	Chain of titl a physician acted.  If Nursing ed and initiated a eet" used for daily urance tracking patient's rin. The flow sheet yely by Pharmacy iew and document nise to Warfarin. discharge, the et is secured in harmacist of completes the w Sheet" for all e drug. During the pharmacist de nurse "Warfarin Flow ne nursing ocumenting or any signs of pharmacist locuments the rito Warfarin ed. The turns the Warfarin pharmacy where	10.10.00 THRU 11.10.6
					Pharmacy An Therapy Trac	king binder until	
vent ID:I4QB11			11/26/2008	7:26:26AM	<del> </del>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plants of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited an approved plan of correction is requisite to continued program participation.

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AND PLAN OF CORRECTION IDENT		(X1) PROVIDER/SUP		A, BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE			
NAME OF PROVID	ER OR SUPPLIER MUNITY MEDICAL CEI	050492 NTER		B. WING 11/06/2008  STREET ADDRESS, CITY, STATE, ZIP CODE  2755 HERNDON AVENUE, CLOVIS, CA 93611 FRESNO COUNTY					
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPR	N SHOULD BE CROSS-				
vent ID:I4QB11			11/26/2008	7:26:264	Warfarin F in the phar assurance (b) INR and W amounts a on the flow pharmacis  6. All pharmacists the Pharmacy N stop process, W interactions, lab process, and im "Warfarin Flow S  7. The pharmacy of the pharmacy of Warfarin drug-di pharmacy referr  8. The Pharmacy a Managers revise policies. a. The Medica Risk/High A revised to i recommend of Healthca (Getting St Harm from Medication: The followin drugs/categ (1) Insulin Hepar Bolus, Electro Magne Potass Neuro Agents	were educated by lanager on the hard larfarin drug-drug values, MD contact plementation of the Sheet."  Iducational binder in ontains potential rug interactions for al.  Ind Nursing ed and expanded two tions- High lart policy was include drugs ded by the Institute in Improvement larted Kit: Prevent High-Alert s, How-to Guide). In glisted gories include: IV Infusion, in Infusion and Concentrated biytes (Sodium, esium and	10.10.00 10.30.06		
ent iD:14QB11			11/26/2008	7:26:26A	M				

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**DECLIDED** 

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		050492	050492			11/06/2008	
NAME OF PROVIDER OR SUPPLIER STREET ADDR				CITY, STATE, ZI	PCODE	<u></u>	
CLOVIS COM	MUNITY MEDICAL CEN	TER 275	55 HERNDON A	AVENUE, CL	OVIS, CA 93611 FRESNO COUNTY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY)	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL C IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS- COMPLETE	
					Warfarin, and a Epidurals. b) The Medication Orders Pharmacist Review porevised to include pharmacity activation of the physic command on 11/3/08.	s- dicy was macist cian chain of	
					<ul> <li>On 10/30/08 all Pharmacists educated by the Pharmacy the Medications –High Risk policy including:</li> <li>a) Drug classifications/High drugs</li> <li>b) Pharmacy actions to be each drug</li> </ul>	Manager on 10.30- /High Alert 11.3.86	
					6) Efforts to recruit 2 additional pharmacists were expedited candidates were identified d October and interviews bega 11/04/08. Offer extended to 1 on 11/04/08, but offer decl extended to candidate 2 on awaiting decision by candidate extended to candidate 3 on candidate accepted offer.	Uviable uring an candidate ined. Offer 11/12/08, atc. Offer	
	,				<ol> <li>Any new pharmacists will rec training on the Warfarin Harc process and high risk/high-ai medication policy prior to me processing.</li> </ol>	Stop Asse	
					8) On 10/23/08, the Warfarin ev discussed at Quality Patient Committee.	vent was Safety 10.23.08	
					On 10/27/08, the Warfarin ev discussed at the facility Medi Management Committee.	rent was cation 10.27.06	
					· .		
vent ID:I4QB11	<u> </u>		26/2008	7:26:26AM			
BORATORY DIREC	TOR'S OR PROVIDER/SL	IPPLIER REPRESENTATIVE	S SIGNATURE		TITLE	(X6) DATE	
survey whether or no	ot a plan of correction is pr	ovided. For nursing homes, the	rsing bomes, the	e findinge abov s and place of	d from correcting providing it is determined to are disclosable 90 days following the discorrection are disclosable 14 days following ection is requisite to continued program		
		·····	DE DE	:C : 2:			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		050492		A. BUILDING B. WING		111	06/2000	
NAME OF PROVIDER OR SUPPLIER CLOVIS COMMUNITY MEDICAL CENTER							11/06/2008	
			STREET ADDRESS, CITY, STATE, ZIP CODE 2755 HERNDON AVENUE, CLOVIS, CA 93611 FRESNO COUNTY					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	PRECEEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
					Adverse drug events or reported through the C Safety committee, med and medication manage committees.	Quality Patient dical staff quality	ONGOI	
				b	. The title or position of responsible for the co	the person orrection.		
					Manager of Pharmacy Director	and Quality		
				C	<ul> <li>A description of the me process to prevent re deficiency.</li> </ul>	onitoring currence of the		
	·				The Pharmacy Manage 100% completion of ed pharmacists. 100% cor achieved on 10/14/08.	ucation with all	10.10- 10.14.0	
					The Pharmacy Manage will monitor compliance Warfarin medication ad perform quality review f Review includes trackin results of PT/INR for 30 through 11/10/08). This is located in the Anti-co in the Pharmacy.	with daily ministration and or all patients. g the dose and days (10/10/08 tracking sheet	11.30.0	
					The Pharmacy Manage "Warfarin Flow Sheets" and 100% compliance f three months.	for completion	1/2009	
					Results of the monitorin reported monthly to Qua Safety Committee and Management Committee	ality Patient	1/2009	
				C.	The date the immediat action will be accompl			
ent ID:I4QB11			11/26/2008	7:26:26AM				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	050492		A, BUILDINI B. WING	G	-	06/2008	
NAME OF PROVIDER OR SUPPLIES	STREET ADDRES	STREET ADDRESS, CITY, STATE, ZIP CODE					
CLOVIS COMMUNITY MEDI	CAL CENTER	2755 HERNDO	N AVENUE, CL	OVIS, CA 93611 FRESNO CO	UNTY	·	
PREFIX (EACH DE	MARY STATEMENT OF DEFIC FICIENCY MUST BE PRECEEL ORY OR LSC IDENTIFYING IN	DED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S	HOULD BE CROSS-	(X5)	
	The state of the s	TORWIATION)	TAG	REFERENCED TO THE APPROP	RIATE DEFICIENCY)	DATE	
				10/10/08 all pharmacis educated. Pharmacis leave were educated beginning of their first new pharmacists will education.	ts on vacation or prior to the shift back, All	10.10-	
ent ID:i4QB11 RATORY DIRECTOR'S OR PRO	VIDER/SUBDITED DEDDE	11/26/2008	7:26:26AM				
The state of the s	VIDEN/SOPPLIER REPRES	SENTATIVE'S SIGNATUR	!É	TITLE	(X6)	DATE	