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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP AND PLAN OF CORRECTION IDENTIFICATION 050060			(X2) MULT A BUILDI B. WING	TIPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
NAME OF PR	ROVIDER OR SUPPLIER	·	STREET ADDRESS.	CITY, STATE	ZIP CODE		
COMMUN	ITY REGIONAL MEDICAL	CENTER			ESNO, CA 93721-1324 FRESN	O COUNTY	
(X4) ID		ATEMENT OF DEFICIENCIE		ID	POC ACPROVIDEB'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		MUST BE PRÉCEEDED BY LSC IDENTIFYING INFORMA	TION)	TAG ewed By:	POCACCERENCE PLAN OF YESEE PACENCE OF THE APPRO	SHOULD BE CROSS- OPRIATE DEFICIENCY)	COMPLETE DATE
	The following reflects t		partment		Name	Amended	
	of Public Health during	an inspection visit:	Mami		Facility Notified	8/9/11 1.B.a 1.B.c	
	Complaint Intake Num	ber:	ine		0 3 4 1 0	- 1.C.a	
	CA00252552 - Substan	ntiated		ad By:	Sandell	- 1.C.d - 3. A	
	Representing the Depa	artment of Public Hea	lth:		Mama	3. D	
	Surveyor ID # 28531, F	FEN	1		Plan of Correction		
	The inspection was lim	ited to the specific fa	cility		CA00252552 The statements made on	the plan of	
	event investigated and				correction are not an adm		
	findings of a full inspec	tion of the facility.			constitute agreement wit deficiencies herein.		
	Health and Safety	Code Section 120	30.1(c): For		The plan of correction co	nstitutes	
	purposes of this				Community Regional Med		
	means a situation		licensee's		written credible allegatio		
	noncompliance with				for the deficiencies noted	r,	
	licensure has caused		ise, serious				
	injury or death to the pa	atient.					
	AMENDED TO C	ORRECT TYPING	ERRORS		1. How the correction wa accomplished, both temp permanently.	= 12 Pi	
	Health and Safety	Code Section 127	9.1(c): "The				
	facility shall inform	the patient or	the party				
	responsible for the p		se event by		A. December 15, 2010: Th		
	the time the report is m	ade."			Director reviewed all pati High Risk High Alert media		
	The CDPH verified	that the facility in	nformed the		for 100% compliance with		12/15/2010
	patient or the party re	esponsible for the p	atient of the		double check performance	e and Alaris SMARI	
	adverse event by the ti	me the report was m	ade.		Pump guardrait usage.		
	Health and Safety Cod	e 1279.1(b)(4)(A)			B. December 16, 2010: All Radiology nurses were edu		
	(b) For purposes of	this section, "adv	erse event"		Risk / High Alert Medicati		12/16/2010
	includes any of the folio	owing:			Procedure. Education incl		,,
Event ID:	M8ND11		7/29/2011	8:14:	34AM		
ABORATOR	Y DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESE	NTATIVE'S SIGNAT	URE	TITLE		X6) DATE
yn,	aren Buck	ly KN	chuy	Nur	using officer	1 8	5/9/11
	12 A		·	100 M 100	excused from correction providing ngs above are disclosable 90 days		
of survey wh	elher or not a plan of correctio	n is provided. For nursing	homes, the above f	indings and p	plans of correction are disclosable 1	4 days following	
the date the participation		ble to the facility. If defici	encies are cited, an a	approved plai	n of correction is requisite to contin	CEINE	nI
	×				11.12		
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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER: 050060		(X2) MUL A BUILD B WING		(X3) DATE SURVEY COMPLETED 12/21/2010	
					12/2	1/2010
	ROVIDER OR SUPPLIER ITTY REGIONAL MEDICAL (STREET ADDRES		E, ZIP CODE RESNO, CA 93721-1324 FRESNO	COUNTY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETE DATE
	with a medication et to, an error involving dose, the wrong patie rate, the wrong prep administration, exclud clinical judgment on dru A012 1280.1(c) Heal (c) For purposes jeopardy" means a si noncompliance with licensure has caused, injury or death to the pa- DEFICIENCY CC JEOPARDY T22 DIV 5 CH Pharmaceutical Servi Medications and Trea as ordered. This RULE is not met a Based on staff in administrative docume administer medication (50 times the amount used to slow the tim given to Patient 1. vessels in Patient1's bru	nent events, including the or serious disability associated ror, including, but not limited g the wrong drug, the wrong aration, or the wrong route of ing reasonable differences in ug selection and dose. th & Safety Code 1280 of this section "immediate tuation in which the licensee's one or more requirements of or is likely to cause, serious thent. INSTITUTES IMMEDIATE 1 ART 3-70263(g)(2) - ce General Requirement atments shall be administered s evidenced by: terview, clinical record and nt review, the facility failed to safely when the wrong dose ordered) of heparin (a drug e it takes blood to clot) was This failure caused blood aln to bleed. This is known		 a. High Risk High Alert Medi Administration-as defined in include; pharmacy involverr medication preparation, inc double checks, medication medication administration. medications include; Chema agents, Insulin (intravenous subcutaneous), Heparin infu Electrolytes (concentrated in preparation), Neuromuscula agents, Vasoactive agents (in intravenous Epinephrine, Do Norepinephrine, Phenylephi Vasopressin), Citrate for Co Replacement Therapy, Pros Alteplase, Warfarin. b. Alarís SMART Pump Guard return demonstration to the designee c. Patient Hand-off-as defin include communication from healthcare team member to that pertinent care, treatm well as the patient's current any recent or anticipated cl accurately communicated w is a transfer of responsibility the patient. C. December 16, 2010: All It during their first shift work December 16, 2010 received education: 	n HRHA policy to bent in lependent storage, and HRHA otherapeutic infusion/ ision and bolus, intravenous in blocking applies only to oparnine, rine, and ntinuous Renal tacyclins, drail usage with the supervisor or ed in policy to n one o another so ent, or needs as condition and hanges are whenever there y for the care of icensed staff ed on or after	12/16/201
Event ID:		7/29/2011 R/SUPPLIER REPRESENTATIVE'S SIGN		TITLE		(X6) DATE
Tha	rin Buckli		Nurse	in Africar	81	9/11
that other sa of survey wh	aleguards provide sufficient prol nether or not a plan of correction se documents are made availab	(e)isk (*) denotes a deficiency which the ins ection to the patients. Except for nursing h in is provided. For nursing homes, the abov we to the facility. If deficiencies are cited, a	omes, the find e findings and	ings above are disclosable 90 days foli plans of correction are disclosable 14	owing the date days following	

STATEMENT OF DEFICIENCIES	5	(X1) PROVIDER/SUPPLI		A BUILD	TIPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	D
		050060		B. WING		12/21	/2010
AME OF PROVIDER OR SUPP	LIER		STREET ADDRESS	, CITY, STATE	, ZIP CODE		
COMMUNITY REGIONAL	MEDICAL	CENTER	2823 FRESNO 8	ITREET, FR	ESNO, CA 93721-1324 FRESNO CO	DUNTY	
PREFIX (EACH	DEFICIENCY	NTEMENT OF DEFICIENCIE MUST 8E PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-,	(X5) COMPLETE DATE
1's intracran death. Findings: The clinical showed P Department chief compl was diagno (vessel which her left arm blood clots into Patient administered was used t catheter (tu There was clinical reco heparin infu was no o verifying th facility polic [without a at 300 unit Radiology Intra-Proced conducted post-proced was: hepa (ml- a liqu solution) in activity rep	I record w vatient 1 on aint of pa sed with a ch carries b. Altepla) was a ch carries b. Altepla) was a 1's clothe d into the o prevent bing) dired no docum and to ind sion was documenta e accurace y. A Raw time] Indic s per his (IR) produce from 6:3 are order rin premi id measu water to port from	was reviewed on arrived at the 10 at 11:11 a.m in in her left arm. a blood clot blockii blood away from t se (a drug used to dministered intrave ed artery. Hepari a same artery. clots from forming cting the flow of ti hented evidence in dicate exactly whe started, or by whi tion by the se by of the pump diology Report data cated the heparin our during the flow codure. Accordi	12/17/10 and Emergency , with the Patient 1 ng an artery the heart) in o breakdown enously (IV) in was then The heparin around the he alteplase. Patient 1's n the initial form. There cond nurse settings per ed 10, was started nterventional ng to the adure was o.m. The at 7:30 p.m. 500 milliliters trose (sugar / hour. An medication		 a. High Risk High Alert Medica Administration-as defined in include; pharmacy involveme medication preparation, inde double checks, medication st medications include; Chemot agents, Insulin (intravenous li subcutaneous), Heparin infus Electrolytes (concentrated in preparation), Neuromuscular agents, Vasoactive agents (ap intravenous Epinephrine, Dop Norepinephrine, Phenylephrin Vasopressin), Citrate for Cont Replacement Therapy, Prosta Alteplase, Warfarin. b. Alaris SMART Pump Guardr return demonstration to their designee c. Chain of Command activati problem solving d. Patient Hand-off as define- include communication from healthcare team member to a that pertinent care, treatmer well as the patient's current of any recent or anticipated cha accurately communicated wh is a transfer of responsibility the patient. 	HRHA policy to int in pendent orage, and RHA herapeutic ion and bolus, travenous blocking oplies only to aamine, ne, and tinuous Renal ccyclins, ail usage with r supervisor or ion for d in policy to one another so it, or needs as condition and inges are enever there	
Event ID:M8ND11			7/29/2011	8:14	:34AM	الرجي تتججيبين	-
BORATORY DIRECTOR'S			NTATIVE'S SIGNA	TURE	ung officer	8	(6) DATE

Any deficiency statement ending with an asteric (*) denotes a deficiency which the institution may be excused from correctly providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MUI		(X3) DATE SU COMPLET		
		050060					/21/2010	
	OVIDER OR SUPPLIER ITY REGIONAL MEDICAL (CENTER	STREET ADDRESS		E, ZIP CODE RESNO, CA 93721-1324 FRESNO			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS- TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE					
Continued From page at 4 p.m. The report p.m., Registered Nurse (RN) 1 removed hepai The report indicated Heparin 25 000 units		indicated on and in from the ADC for the heparin was pr	or Patient 1.		 D. December 15, 2010: TI Manager counseled the nu administered the Heparin the patient and failed to the Procedural Record. E. June 1, 2011: All Radio 	and Alteplace to properly complete	12/15/201	
Heparin 25,000 units in 500 ml of solutio The nurse's note written by RN 2, da 7:50 p.m., noted Patient 1 was tran burn unit after the IR procedure and stated, Heparin gtt [drip or iV inf			rred to the at "IR nurse on] @ sub		reeducated about completincluding: a. Documentation of mediadministration b. Do not leave blanks. If doesn't apply, write "N/A"	cation a component	08/01/201	
	therapeutic level @ 300/ hr" The documented evidence to clarify if the 3 units or ml per hour.		0 referred to		c. Document baseline vita already completed by the	l signs if not		
2	Patient 1's Medica (MAR) dated of heparin solution Patient 1. RN 2 doc had begun administre	had been admi	st container inistered to AR that she		 d. Complete the Post-Proc for outpatients. e. Complete the In-Patien inpatients. 			
	heparin at 9:10 p.m. information was on 25,000 units in 500 n concentration of "50	The following Patient 1's MAR: nl of solution, res	pre-printed Heparin: sulting in a		f. Complete the Procedura Plan and Education.	al Patient Care		
	300 UNITS/HR = 6 ML/HR *** HIGH ALERT / HIGH RISK MED [HAHR] ***" This order showed how the heparin was to be administered. There were no signatures or initials on the MAR except RN 2's. There was no documented evidence that double checks were performed per facility policy.				2. The title or position of responsible for the corre Chief Nursing Officer Medical Imaging Director Burn Unit Director	a second s		
	On 10 10 at 1 notification that Patie Time (PTT) was gre was a test to measure of	ater than 120 sec	onds. (PTT					
Event ID:	M8NID11		7/29/2011	8:14	:34AM			
Kar	0.1.10000101	eng EN	Cri	if N	Wising Office	er B	(X8) DATE	

Any deficiency statement ending with an asterisk (a denotes a deficiency which the instituto) may be excused from edirecting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State-2567



WAME OF PROVIDER OR SUPPLIER STREET ADDRESS, GITY, STATE, 2P CODE COMMUNITY REGIONAL MEDICAL CENTER 2323 FRESNO STREET, FRESNO, CA 83721-1324 FRESNO COUNTY (241 ID PRETX TXC SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERCIENCY MUST BE ERRECEDED BY FULL RECULTORY OR LSC IDENTER YING INFORMATION) ID PRETX RECULTORY INFORMATION INFORMATION A THE ADDRET YING INFORMATION RECULTORY OR LSC IDENTER YING INFORMATION A THE PRATICE YING INFORMATION RECULTORY INFORMATION RECULTORY INFORMATION RECULTORY OF INTEGED INFORMATION RECULTORY INFORMATION RECULTORY INFORMATION INFORMATION RECULTORY INFORMATION RECULTORY INFORMATI	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050060	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/21/2010
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEEDED & FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGERENCED TO THE APPROPRIATE DEFICENCY) Comin References on the appropriate Deficiency. Comin References on the appropriate Deficiency. Comin References Deficiency. Comin References D				
 greater than 36.5 seconds are considered excessive). Narrative nurses notes dated 10 at 11:30 p.m., written by RN 2 contained to compare improgramming for Heparin" This note indicated the discovery of heparin being administered incorrectly. A late entry on 10 at 6:14 e.m., RN 2 documentation of independent double checks and compliance with use of the datars SMART Pump Guardrall system on all High Risk High Alert medications which per documentation of hopenine that so and output record dated 10.5 p.m. Review of Patient 1's intake and Output record dated 10.3 p.m. Patient 1 received 820 ml or 41,500 units of heparin between 6:36 p.m. and 10:35 p.m. Patient 1 received 820 ml or 41,500 units of heparin between 6:36 p.m. and 10:35 p.m., contained the following: "Disclosure Note - was called to the patient period the heparin infusion. Therefore, Patient 1 received 3 ingerts (applies only to intravenous preparation), Revromuscular blocking agents, Vasoactive agents (applies only to intravenous preparation), Neuromuscular blocking agents, Vasoactive agents (applies only to intravenous preparation), Neuromuscular blocking agents, Vasoactive agents (applies only to intravenous preparation), Neuromuscular blocking technology, Continuous Renal Replacement Therapy, Prostacyclins, Atteplase, and Warfarin being delivered from 12/17/10 to 12/31/10, Continuous Renal Replacement Therapy, Prostacyclins, Atteplase, and Warfarin being delivered from 12/17/10 to 12/31/10, Continuous Renal Replacement Therapy, Prostacyclins, Atteplase, and Warfarin being delivered from 12/17/10 to 12/31/10, Continuous Renal Replacement Therapy, Prostacyclins, Atteplase, and Warfarin being delivered from 12/17/10 to 12/31/10. A Physician's Progress note dated 10 to a bigher dose of heparin than ordered, at 300 mi/hr. rether than 300 units/m. Pt. (patient) continued to one on a monthly basis. B. The manager or designee of each patient care unit performed the audits sonthey. The audits continue to be done on a mont	REFIX (EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREFIX (EACH CORRECTIVE ACT	ION SHOULD BE CROSS- COMPLET
brain,	greater than 36. excessive). Narrative at 11:30 p.m., we documentation, "pur programming for Hep discovery of heparin A late entry on documented the hepa at 10:35 p.m. Review of Patient dated 10, sho Patient 1 received. 41,500 units of hep 10:35 p.m. Patient 1 hour for the three to infused. Therefore, dose of heparin that wa A Physician's Prog 12:55 p.m., containe Note - was called approximately [10 p.m. discovered that the p of heparin than ordered than 300 units/hr I stable but now had headache, at this po that she had received ordered by MD 2" that Patient 1 may ha wrote that the Com definition computer results Indicated them	5 seconds are considered e nurses notes dated 10 inition by RN 2 contained up noted to have improper arin" This note indicated the being administered incorrectly. 10 at 6:14 a.m., RN 2 arin was stopped on 10 if's intake and Output record wed hourly totals of heparin Patient 1 received 829 ml or harin between 6:36 p.m. and should have received 6 ml an o four hour period the heparin Patient 1 received 50 times the as ordered by the physician. ress note dated 10 at d the following: "Disclosure to the patient bedside at h.] due to critical tab value patient received a higher dose d, at 300 ml/hr. rather P1. (patient) continued to be an occipital [back of hepatient a higher dose of hepatient than MD 1 documented concern ave a bleed in her head. He puted Tomography (CT) (high tomography- scanned views)	 to prevent recurrence A. The manager or desi care unit performed da documentation of indep checks and compliance Alaris SMART Pump Gua High Risk High Alert me policy to include Cheme Insulin (intravenous infi Heparin infusion and bo (concentrated intravenon Neuromuscular blocking agents (applies only to Epinephrine, Dopamine Phenylephrine, and Vas Continuous Renal Repia Prostacyclins, Alteplase delivered from 12/17/1 weekly audits from 1/1 and until 100% compliance manager or designee of unit performed the aud audits continue to be d basis. B. The manager or desi care unit ensured that a competency in the use Pump Guardrail System education and signed th at 100% compliance ratu 	ignee of each patient ily audits for pendent double with use of the ardrail system on all edications which per otherapeutic agents, usion/subcutaneous), olus, Electrolytes ous preparation), g agents, Vasoactive intravenous e, Norepinephrine, sopressin), Citrate for acement Therapy, e, and Warfarin being 10 to 12/31/10, /11 for four weeks nee was achieved, the f each patient care fits monthly. The one on a monthly gnee of each patient all RN's demonstrated of the Alaris SMART and completed the he attestation form e.

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 80 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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PHERX TAG RECHORECTIVE ACTON SHOLD BE CROSS- REFERENCE TO THE APPROPRIATE DEFICENCY Co. Continued From page 5 Continued From page 5 Continued Patient 1's condition had worsened with a decreased level of consciousness. The CT report concluded the bieding in Patient's brain had developed into a very targe subdural hematoma (a space in the brain created by an abnormal collection of blood). The subdural hematoma had grown and was crowding Patient 1's brain. C. Education and audits have been monitored by the Chef Nursing Officer for 100% compliance in all patient care areas that use High Risk High alert medications and Alaris SMART Pumps. This was completed by 12/31/10. 12/3 Progress Notes dated 10 at 11:35 p.m. were reviewed. MD 3 documented in the progress notes that Patient 1 did on 12/17/10 at 10:20 a.m. She stated the amount of heparin ordered for Patient 1 was 300 units an hour. instead of 300 units an hour. The Risk Manager 1 stated. The R nurse programmed the pump (equipment used to precisely administer IV medication to administer 300 ml an hour, instead of 300 units an hour. The reviewed on 10 to at 10:35 p.m." During the interview, Risk Manager 1 stated the offer the following: By that time, Patient 1 had been receiving 15,000 units of heparin an hour for approximately three hours. The amount of heparin the physician ordered for Patient thas bour on the nore at the patient 1 had been received 15,000 units of heparin an hour. Fatient 1 received an overdose of 40,500 units of heparin hep recised or advisits of the patient the procedural nurse. C. Education and audits have been monitored by the Chief Nursing Officer and Quality Patient 09/01 Coll coll coll coll coll coll coll coll		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 050060		(X2) MUL A. BUILD B. WING		(X3) DATE SUI COMPLET 12/2	
PREFIX TAG IEACH OBFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC DENTFYING MEDIATORY PREFIX TAG IEACH OBFICITIE APROPRIATE DEFICIENCY Construct a constance and must be precessory Construct a construction and audits have been monitored by the Chief Nursing Officer for 100% compliance in all pattent care areas that a decreased level of consciousness. The CT report concluded the bleeding in Patient's brain had developed into a very large subdural hematoma (a grown and was crowding Patient 1's brain. C. Education and audits have been monitored by the Chief Nursing Officer for 100% compliance in all pattent care areas that brain created by an anbornal collection of blood). The subdural hematoma (a grown and was crowding Patient 1's brain. D. 2/20/11: An laris consultant independently reviewed Alaris SMART Pumps settings and use of Guardralis with random audits. 100% compliance was found which intruded correct settings on all Alaris SMART Pumps audited along which included correct settings on all Alaris SMART Pumps audited along which included correct settings on all Alaris SMART Pumps audited along which included correct settings on all Alaris SMART Pumps audited along which included correct settings on all Alaris SMART Pumps audited along which included correct settings on all Alaris SMART Pumps audited along which included correct settings on all Alaris SMART Pumps audited along which included correct settings on all (2/2 C. Enter SMART Pumps audited along which included correct settings on all inpatient thromobilysis procedures in IR to ensure complete documentation by the procedural nurse. 05/01 05/01 05/01			CENTER			· Labora De la construire		
A CT of Patient 1's brain dated 10 at 7:46 a.m. indicated Patient 1's condition had worsened with a decreased level of consciousness. The CT report concluded the bleeding in Patient's brain had developed into a very large subdural hematoma (a space in the brain created by an abnormal collection of blood). The subdural hematoma had grown and was crowding Patient 1's brain. Progress Notes dated 10 at 11:36 p.m. were reviewed. MD 3 documented in the progress notes that Patient 1'died on 120 to 11:36 p.m. were reviewed. MD 3 documented in the progress notes that Patient 1'died on 120 to 11:27/10 at 10:20 a.m. She stated the amount of heparin ordered for Patient 1's about. Needed for Patient	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY	FULL	PREFIX	EACH CORRECTIVE ACTION SHOUL	D BE CROSS-	(X5) COMPLETE DATE
 space in the brain created by an abnormal collection of blood). The subdural hematoma had grown and was crowding Patient 1's brain. Progress Notes dated 10 at 11:35 p.m. were reviewed. MD 3 documented in the progress notes that Patient 1 died on 10 to 11:35 p.m. were reviewed. MD 3 documented in the progress notes that Patient 1 died on 10 to 10. The time of death was 11:20 p.m. MD 3 indicated the immediate cause of death was due to brain hemorrhage. Risk Manager 1 was interviewed on 12/17/10 at 10:20 a.m. She stated the amount of heparin ordered for Patient 1 was 300 units an hour. The progress notes discovered on 10 to administer 300 ml an hour, instead of 300 units an hour. The error was discovered on 10 to administer 300 ml an hour, instead of 300 units an hour. The error was discovered on 10 to at 10:35 p.m." During the interview, Risk Manager 1 stated the following: By that time, Patient 1 had been receiving 15,000 units of heparin an hour for approximately three hours. The amount of heparin the physician ordered for Patient 1 was 300 units on heparin over a three to four hour time period. During a second interview on 12/17/10 at 11:30 a.m., Risk Manager 1 stated the nurse that 		A CT of Patient 1's brain dated 10 at 7:4 a.m. indicated Patient 1's condition had worsen with a decreased level of consciousness. The C report concluded the bleeding in Patient's brain his developed into a very targe subdural hematoma		d worsened s. The CT		monitored by the Chief Nursing 100% compliance in all patient that use High Risk High alert m and Alaris SMART Pumps. This	g Officer for care areas edications	12/31/201
 Was 11:20 p.m. MD 3 indicated the immediate cause of death was due to brain hemorrhage. Risk Manager 1 was interviewed on 12/17/10 at 10:20 a.m. She stated the amount of heparin ordered for Patient 1 was 300 units an hour. The Risk Manager 1 stated. "The IR nurse programmed the pump (equipment used to precisely administer IV medication) to administer 300 ml an hour, instead of 300 units an hour. The error was discovered on 10 at 10:35 p.m." During the interview, Risk Manager 1 stated the following: By that time, Patient 1 had been receiving 15,000 units of heparin an hour for approximately three hours. The amount of heparin the physician ordered for Patient 1 was 300 units an hour. Patient 1 received an overdose of 40,500 units of heparin over a three to four hour time period. During a second interview on 12/17/10 at 11:30 a.m., Risk Manager 1 stated the nurse that E. The Radiology Manager monitored for 100% compliance by Radiology Manager or his designee will perform audits on all inpatient thrombolysis procedures in IR to ensure complete documentation by the procedural nurse. G. Beginning June 1, 2011 through September 1, 2011 through September 1, 2011 through September 1, 2011 the Radiology Manager or his designee will perform 30 random audits a month on IR procedures to ensure complete documentation by the procedural nurse. H. Audit results will be reviewed by the Chief Nursing Officer and Quality Patient Safety Committee. 		space in the brain collection of blood). grown and was crowdin Progress Notes date	n created by an The subdural her ng Patient 1's brain. d 111111 10 at 11131	abnormal natoma had 5 p.m. were		independently reviewed Alaris settings and use of Guardrails v audits. 100% compliance was for included correct settings on all SMART Pumps audited along wi	SMART Pump with random bund which Alaris th 100% of	02/20/20
 10:20 a.m. She stated the amount of heparin ordered for Patient 1 was 300 units an hour. The Risk Manager 1 stated, "The IR nurse programmed the pump (equipment used to precisely administer IV medication) to administer 300 ml an hour, instead of 300 units an hour. The error was discovered on 10 at 10:35 p.m." During the interview, Risk Manager 1 stated the following: By that time, Patient 1 had been receiving 15,000 units of heparin an hour for approximately three hours. The amount of heparin the physician ordered for Patient 1 was 300 units an hour. Patient 1 received an overdose of 40,500 units of heparin over a three to four hour time period. During a second interview on 12/17/10 at 11:30 a.m., Risk Manager 1 stated the nurse that F. Beginning June 1, 2011 through September 1, 2011 through September 1, 2011 through September 1, 2011 the Radiology Manager or his designee will perform 30 random audits a month on IR procedures to ensure complete documentation by the procedural nurse. H. Audit results will be reviewed by the Chief Nursing Officer and Quality Patient Safety Committee. G. Beginning June 1, 2011 through September 1, 2011 through September 1, 2011 through September 1, 2011 through September 1, 2011 the Radiology Manager or his designee will perform 30 random audits a month on IR procedures to ensure complete documentation by the procedural nurse. H. Audit results will be reviewed by the Chief Nursing Officer and Quality Patient Safety Committee. 		was 11:20 p.m. M cause of death was due	ID 3 indicated the a to brain hemorrhage	immediate e.		100% compliance by Radiology education on documentation be	nurses for eginning	06/02/20:
discovered on 10 at 10:35 p.m." During the interview, Risk Manager 1 stated the following: By that time, Patient 1 had been receiving 15,000 units of heparin an hour for approximately three hours. The amount of heparin the physician ordered for Patient 1 was 300 units an hour. Patient 1 received an overdose of 40,500 units of heparin over a three to four hour time period. During a second interview on 12/17/10 at 11:30 a.m., Risk Manager 1 stated the nurse that		ordered for Patient 1 Risk Manager 1 state the pump (equipment IV medication) to	was 300 units an d, "The IR nurse j t used to precisely administer 300 ml	hour. The programmed administer an hour,		September 1, 2011 the Radiolo or his designee will perform au inpatient thrombolysis procedu ensure complete documentatio	gy Manager dits on all ires in IR to	09/01/20
to four hour time period. During a second interview on 12/17/10 at 11:30 a.m., Risk Manager 1 stated the nurse that H. Audit results will be reviewed by the Chief Nursing Officer and Quality Patient Safety Committee.		discovered on interview, Risk Manag that time, Patient 1 h of heparin an hour The amount of hepa Patient 1was 300 unit	10 at 10:35 p.m." ger 1 stated the foil ad been receiving for approximately th arin the physician s an hour. Patient	During the lowing: By 15,000 units hree hours, ordered for t 1 received		September 1, 2011 the Radiolog or his designee will perform 30 audits a month on IR procedure complete documentation by the	gy Manager random es to ensure	09/01/203
		to four hour time period During a second int a.m., Risk Manage	terview on 12/17/1 In 1 stated the	0 at 11:30 nurse that		Chief Nursing Officer and Quali		Ongoing SC
Event ID:M8ND11 7/29/2011 8;14:34AM BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X8) DA	Event ID:	18ND11		7/29/2011	8:14			(X6) DATE

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Any deficiency statement ending with an asteriak (*) denotes a deficiency which the institution may be accused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plen of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E.C. CANALESCOLE CO.C.	t of deficiencies Of Correction	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		050060		B. WING		12/2	1/2010
	ROVIDER OR SUPPLIER INTY REGIONAL MEDICAL (REET ADDRESS, (3 FRESNO ST		ZIP CODE ESNO, CA 93721-1324 FRESNO (COUNTY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FUL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETE DATE
	built in safety mechan parameters (doses to medications, such as pumps will not accel pre-set safe paramet "Our policy is to u bypassed the guard rai programmed Patient	rdrails." The guardra nism that recognize w o high or too low) of heparin, are not mo ot doses that are ou ers. Risk Manager se the guard rails.	hen safe high risk et. The tside the 1 stated, RN 1 ere going		4. The date the immediate the deficiency will be acco Normally this will be no m days (30) from the date of conference. December 31, 2010	omplished. ore than thirty	12/31/2010
	Burn Unit Director sta certain checks when patient. Those assessment of the orders, and checking Double checks were was handed-off from of communication and cl documented. The sta (HAHR) medication re dose settings. This documented - meaning they verified it to be check should have on of the HAHR medication. It we responsibility to dout	and, during an inter- ated RN's were respon- they took over the c checks included: patient, checking the the settings on the required when pati- one nurse to another. hecks were not requin- art of a High Alert H quired two nurses to the s double check was g both nurses would accurate. The sam- ccurred when a new dication replaced ar ras the receiving ble check. The B 2] admitted this was the	nsible for are of a physical doctor's pumps. ent care Hand off ed to be ligh Risk verify the s to be sign that e double container i empty nurse's urn Unit		940		
	The facility policy and High Risk [HAHR] Medi	I procedure titled "Hig cations - Patient Care	h Alert /		1.		
Event ID:	M8ND11		7/29/2011	B:14:	34AM		
ABORATOR					TITLE		(X6) 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 findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	t of deficiencies Of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTO	PLE CONSTRUCTION	(X3) DATE SU COMPLET	
	1	050060	B. WING	· · · · · · · · · · · · · · · · · · ·		1/2010
	ROVIDER OR SUPPLIER	STREET ADDRESS	and the second second	IP CODE SNO, CA 93721-1324 FRESN	O COUNTY	-
(X4) JD PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRI	SHOULD BE CROSS-	(X5) COMPLETE DATE
	indicated, " DEFIN RISK medications techniques are define shown to actually or potentially patient, even when use as intended H Heparin infusion (s larger dose) HAND provision of commu- team member to an transfer of responsibil Independent Double does not require of DOUBLE CHECK - Is performed independen healthcare practitione not limited to: Ri setting (if applicabl applicable) INDEPE WHO? Two registe initial pump prog- replacement Double MAR or medication Use of Guardrails S be run through Alarti- Guardrails System BASIC (NFUSION M policy and jeopardizes The facility failed to:	992, Effective Date 2/23/09, ITION - HIGH ALERT/ HIGH and/ or administration ed as: Those that have been cause significant harm to the ed RHA Medications include: teady drip] and bolus [single, 0 OFF Communication Is the nication from one healthcare oother Whenever there is a lity for the care of the patient. check at Hand off is done but co-signature. INDEPENDENT is a check of the factors below ently by a second qualified r. Checks include, but are ght dose of drug IV pump le) - Rate of infusion (if INDENT DOUBLE CHECK- ared nurses WHEN? Upon frow sheet as appropriate afety System- All drugs must is [Manufacturer's brand name] DO NOT RUN DRUG IN NODE, this violates corporate patient safety."				
Event ID:	M8ND11	7/29/2011	8:14:3	4AM		
Ka	NO BUCK	ERISUPPLIER REPRESENTATIVE'S SIGNA	TURE	y Officer	Bla	(X8) DATE

Any deficiency alatement ending with an asterisk (*) denotes a deficiency which he institution may be exclused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 50 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program narricipation.

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participation. 5 R. 11 fr. h E 8 of 9 State-2567 . MM . 0 2011 ř Construction . LECENSE SC TOPSNT

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLI		(X2) MULT	IPLE CONSTRUCTION		(X3) DATE SU COMPLET	
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	professionals docum notes; ensure that properly programmed healthcare profession per facility policies healthcare profe	tered heparin at acturer's instruction heparin; ensure ented treatment a equipment (IV and operated by a als communicated s and procedure essionals inde prect drug dose, infusion per facility a large intracranial irs from the disco hat has caused, or or death to the p an immediate jeop and Safety Code 128 prevent the deficie caused, or is likely in to the patient, an ediate jeopardy	ns for the healthcare and signed pump) was staff; ensure at hand-off es; ensure pendently IV pump policy and bleed and very of the is likely to patient, and bardy within 60.1. ncy(ies) as y to cause, d therefore within the					
Event ID:N	M8ND11		7/29/2011	8:14:3	HAM			
HA	Y DIRECTOR'S OR PROVIDE	RISUPPLIER REPRESEN	VTATIVE'S SIGNAT	NIE NIE	rsing Of	Ficer	E	(Xe) DATE
ihat other sai of survey wh	cy statement ending with an as leguards provide sufficient pro lether or not a plan of correction e documents are made availab	ection to the patients. Ex n is provided. For nursing	cept for nursing hon homes, the above f	nes, the findin Indings and p	gs above are disclosable 90 lans of correction are disclo	days following li sable 14 days fol	ne date lowing	A.
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