CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050102	A. BUILDING _____ B. WING _____	02/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW COMMUNITY HOSPITAL MEDICAL CENTER	3865 Jackson St, Riverside, CA 92503-3919 RIVERSIDE COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00513419 - Substantiated Representing the Department of Public Health: Surveyor ID # 2829, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.3(g): For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient. Health & Safety Code Section 1280.3 (a): (a) Commencing on the effective date of the regulations adopted pursuant to this section, the director may assess an administrative penalty against a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 for a deficiency constituting an immediate jeopardy violation as determined by the department up to a maximum of seventy-five thousand dollars ($75,000) for the first administrative penalty, up to one hundred thousand dollars ($100,000) for the second subsequent administrative penalty, and up to one hundred twenty-five thousand dollars ($125,000) for the third and every subsequent violation. An administrative penalty issued after three years from			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

By signing this document, I am acknowledging receipt of the entire citation packet, *Page(s). 1 thru 7*

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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	the date of the last issued immediate jeopardy violation shall be considered a first administrative penalty so long as the facility has not received additional immediate jeopardy violations and is found by the department to be in substantial compliance with all state and federal licensing laws and regulations. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section. A0026 1279.1 (b) (4) (A) HSC Section 1279 (b) For purposes of this section, "adverse event" includes any of the following: (4) Care management events, including the following: (A) A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose. Title 22 of the California Code of Regulations section 70263 (g) (2) Pharmaceutical Service General Requirement (g) No drugs shall be administered except by licensed personnel authorized to administer drugs and upon the order of a person lawfully authorized to prescribe or furnish. This shall not preclude the administration of aerosol drugs by respiratory therapists. The order shall include the name of the drug, the dosage and the frequency of			

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	administration, the route of administration, if other than oral, and the date, time and signature of the prescriber or furnisher. Orders for drugs should be written or transmitted by the prescriber or furnisher. Verbal orders for drugs shall be given only by a person lawfully authorized to prescribe or furnish and shall be recorded promptly in the patient's medical record, noting the name of the person giving the verbal order and the signature of the individual receiving the order. The prescriber or furnisher shall countersign the order within 48 hours. (2) Medications and treatments shall be administered as ordered. Findings: Based on interview and record review, Registered Nurse (RN) 1 failed to ensure Dopamine (a medication used in the treatment of severe hypotension [low blood pressure]) intravenous (IV) infusion was administered as ordered by the physician. The RN discontinued the medication Dopamine without a physician's order which contributed to Patient A sustaining a cardiac arrest resulting in the patient's death. On December 22, 2016, at 8 a.m., an unannounced visit to the facility was conducted for the purpose of investigating an entity reported adverse event. On December 22, 2016, at 10 a.m., the Emergency Department Director (EDD) and Chief Quality Officer			

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	(CQO) were interviewed. The EDD stated she was responsible for the facility's investigation of the events leading to Patient A's death. The EDD stated her investigation revealed RN 1 was assigned to transport Patient A from the Direct Observation Unit (DOU) to the Nuclear Medicine department for a procedure. The primary nurse provided a report and told RN1 that the patient was septic. The EDD stated RN 1 discontinued Patient A's IV Dopamine drip prior to transporting Patient A to Nuclear Medicine. There was no documentation that indicated the time RN1 discontinued the Dopamine. The EDD stated RN 1 thought the IV bag was an antibiotic. The EDD stated there was no physician's order to discontinue Patient A's Dopamine medication prior to transporting. The CQO stated her investigation determined RN 1 "Did not read the label (on the IV bag)." The CQO stated, "No medication should be stopped prior to transport without the physician's order." On December 22, 2016, Patient A's record was reviewed. Patient A was admitted to the facility on November 28, 2016, with diagnoses that included end stage renal failure and arteriosclerotic vascular disease (a disease of the blood vessels in which plaque builds up in the lining of the artery walls). The physician's order dated December 1, 2016, at 10 a.m., indicated, "... (indicated decreased) B/P (blood pressure). Transfer to D.O.U. for a Dopamine drip (iv infusion)."			

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	The document titled, "Adult ICU (intensive care unit) Infusion Medications," dated December 1, 2016, at 10 a.m., indicated, "Dopamine 400 milligrams/250 milliliters dextrose 5% in water, 1 to 10 micrograms/kilogram/minute (mcg/kg/min), adjust to maintain mean arterial pressure greater than 65 and systolic blood pressure greater than 90." The "DOU Narrative/Interventions," dated December 2, 2016, indicated: - "...0939 (9:39 a.m.) BP 78/50, Dopamine titrated from 7 mcg/kg/min 0942 (9:42 a.m.) BP 84/65" - "1000 (10:00 a.m.) BP 99/44 Dopamine at 8 mcg/kg/min (physician's order maximum dose is 10 mcg/kg/ml)" - "1415 (2:15 p.m.) Received call from (name of staff) Nuclear Medicine inquiring if patient is ready for procedure...will likely send for patient by 1700 (5 p.m.) since the patient has ate for lunch"; - "...1558 (3:58 p.m.) Patient going off the floor to Nuclear Medicine...accompanied by transport RN (RN 1)." The "CODE BLUE ARREST SUMMARY," dated December 2, 2016, at 4:56 p.m. (58 minutes after leaving the DOU) indicated Patient A did not have a blood pressure. The summary further indicated, "1653 (4:53 p.m.) Arrived to nuclear medicine to find CPR(Cardiopulmonary Resuscitation- a lifesaving procedure) in progress. Pt. was asystole (no heart beat) c (with) absent respirations during			

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HIDA scan (hepatobiliary scan - an imaging procedure used to diagnose problems in the liver) per transport nurse. 1655 (4:55 p.m.) - RRT (rapid response) c'd (changed) to code blue...1700 (5 p.m.) - Pt intubated...17:01 (5:01p.m.) Pt. transferred to ICU (Intensive Care Unit)."

The record indicated Patient A was pronounced dead on December 2, 2016, at 8:37 p.m., three hours and 19 minutes after being transported from DOU to Nuclear Medicine.

On December 22, 2016, at 11:30 a.m., RN 1 was interviewed. RN 1 stated, "I assumed the bag was antibiotic." RN 1 stated he did not look at the label of Patient A's IV bag prior to discontinuing the medication. He further stated he did not get report from the unit RN prior to transporting the patient.

The physician's progress note dated December 8, 2016, at 10 p.m., indicated "IM (internal medicine) addendum, Family was notified that dopamine was discontinued w/o (without) an order prior to the patient being taken to a scheduled radiology procedure. During the scheduled procedure, the patient's condition deteriorated progressively due to her end stage combined conditions and a code blue was called."

Patient A's death certificate indicates the immediate cause of death was acute respiratory failure. The death certificate lists end stage renal disease as a condition that led to the acute respiratory failure.

RN 1 discontinued the Dopamine intravenous

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	infusion used to maintain the patient's blood pressure (blood flow) to various organs including, the patient's heart without a physician's order. When the Dopamine was discontinued, Patient A's blood pressure decreased. With this decrease in blood pressure, Patient A's heart and other vital organs could not function. Patient A subsequently died. This facility failed to prevent the deficiency(ies) as described above that caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.3(g).			

Parkview
Community Hospital
Medical Center

March 22, 2018

California Department of Public Health
Licensing and Certification Program
Riverside District Office
ATTN: Theresa Hawkinson, HFE Supervisor
625 East Carnegie Drive, Suite 280
San Bernardino, CA 92408

RE: **CA00513419 - Plan of Correction**
Facility ID: 250000044
Penalty Number: 250013873

The following plan of correction is submitted for your review and approval:

T22 DIV5 CH1 ART3-70263(g)(2) Pharmaceutical Service General Requirements

1. The adverse event was reported to the Governing Board. **(January 25, 2017 and February 22, 2017))**
2. A "Medication Pass Tool" was developed and implemented to observe and educate nurses on the process of medication administration which includes ensuring the physician's order(s) is carried out (to administer to the patient and/or discontinue the medication). This educational process is supervised by the Nursing Unit Directors in collaboration with the Director of Education. **(January 19, 2017)**
3. The nurse involved was provided and individual action plan which included hand-off communication, medication administration process, documentation and assessment. **(December 7, 2016)**
4. Adverse events will be reviewed via the Root Cause Analysis to identify root causes and possible corrective actions. The Medication Safety Committee meets to identify trends and patient outcomes to address the safe administration of medications.
5. The responsible person(s) to ensure that the medication process is adhered to are the Nursing Unit Directors.

Thomas J. Santos, R.N.
Chief Quality Officer

copy
ms Hynes
3/26/18

3865 Jackson Street, Riverside, CA 92503 (951) 688-2211 pchmc.org