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
	050077	A. BUILDING _____ B. WING _____	07/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scripps Mercy Hospital	**4077 5th Ave, San Diego, CA 92103-2105 SAN DIEGO COUNTY**

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00360799 - Substantiated Representing the Department of Public Health: Surveyor ID # 22479, 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 1280.1(c): 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. The following reflects the findings of the California Department of Public Health during the investigation of Entity Reported Incident : CA00360799 Representing the Department: 1914 1280.1 (a) Health and Safety Code Section 1280 (a) If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed			

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Event ID:M5S711 10/9/2014 3:23:00PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Chief Executive | (X6) DATE: 10.27.14

By signing this document, I am acknowledging receipt of the entire citation packet, *Page(s). 1 thru 12*

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined ...at 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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	twenty-five thousand dollars (25,000) per violation. (c) 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 a patient. (d)This section shall apply only to incidents occurring on or after January 1, 2007. With respect to incidents occurring on or after January 1, 2009, the amount of the administrative penalties assessed under subdivision (a) shall be up to one hundred thousand dollars ($100,000) per violation. With respect to incidents occurring on or after January 1, 2009, the amount of the administrative penalties assessed under subdivision (a) shall be up to fifty thousand dollars ($50,000) for the first administrative penalty, up to seventy-five thousand dollars ($75,000) for the second subsequent administrative penalty, and up to one hundred thousand dollars ($100,000) for the third and every subsequent violation. An administrative penalty issued after three years from 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. 1279.1. (a) A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later			

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	than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law. (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. A tag 001 The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made. Title 22 Regulations 70263 (g) (2) Medications and treatments shall be administered as ordered. 70213 (a) Written policies and procedures shall be developed, maintained and implemented by the		70263 (g) Medications and treatments shall be administered as ordered. Medication Not Given – Medication Administration Policy Responsible Person: Chief Nurse and Operations Executive Immediately after the event the following actions were taken: Leadership notification occurred on 7/1/13 and the investigation was initiated, staff were interviewed and placed on administrative leave. Meetings on 7/2/13 at 8:00am, 11:30 am, 2:00pm, and 5:00 pm, and on 7/3/13 at 8:30am, 11:00am and 3:30pm, and Root Cause Analysis on 7/3/13 at 1:00pm to assess gaps in practice vs policy/best interests of patient to ensure that processes are put in place to prevent immediate risk to future patients. Education on Patient Advocacy in Critical Lab Values and Therapeutic Intervention and Professional Obligations process was initiated on 7/2/13. (Attachment 1: Education Content and Rosters) Corrective Action. The three employees involved in this event were placed on administrative leave and appropriate corrective action and education commenced. (Attachment 2: Administrative Leave Letters) SSRS Competencies. All ED SSRS nurses were oriented to the Pyxis profile process upon beginning of shift. (Attachment 3: Orientation and Competency Checklist)	

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	nursing service. 70213 (d) Policies and procedures that require consistency and continuity in patient care, incorporating the nursing process and the medical treatment plan, shall be developed and implemented in cooperation with the medical staff. The above regulations were NOT MET as evidenced by: Based on interview, document and record review the hospital failed to ensure that nursing staff administered a medication to Patient 1to treat a life threatening serum potassium (a mineral normally found in the body that conducts electrical impulses in the heart) level. Untreated critically high levels of potassium in the blood can lead to cardiac arrest and death. Patient 1 continued to have untreated critically high serum potassium levels prior to her cardiac arrest and death on 7/1/13. Nursing staff failed to implement multiple hospital policies and procedures to include, "Chain of Command" and "Critical Results Reporting", and "Medication Administration." In addition, nursing staff failed to update and communicate pertinent information regarding Patient 1's status to physicians. Findings: On 6/30/13, Patient 1 was admitted to the hospital via the Emergency Department (ED) with diagnoses of acute urinary tract infection, acute renal failure (abrupt loss of kidney function) and hyperkalemia		Subsequent to the event the following actions were taken: Emergency Department Action: The involved ED RN was placed on Administrative Leave with subsequent corrective action completed on 07/10/13. Unit Education: All *Emergency Department* nursing staff received Patient Advocacy training, to include the expectation that if a medication is not available timely, follow up communication to pharmacy occurs to ensure that the medication is given as ordered. (Attachment 1: Education Content and Rosters) This education was initiated on 07/03/13 and continued each shift until 100% completion. Pyxis Orientation: Site orientation for Scripps Systemwide Resource Services (SSRS) Emergency Department (ED) nurses now includes specific orientation to the profiled medication feature unique to the Mercy campus' Emergency Departments; revision to the Checklist was made. (Attachment 3: Orientation and Competency Checklist) Monitoring: A random audit of a minimum of 70 Emergency Department charts per month was conducted to confirm compliance with medication administration as ordered by the physician. (Attachment 4: ED Nursing Audit) Compliance rates were reported monthly to the Quality Assurance and Performance Improvement Committee (QAPIC), where data trends were tracked and analyzed. Ongoing process or performance improvements were monitored and/or revised to ensure compliance with stated action plan. Adjustments to the frequency and scope of audits were made under the direction of QAPIC.	07/23/13 07/29/13 08/26/13

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	(higher than normal levels of potassium in the circulating blood) according to the ED physician, Medical Doctor 1's (MD 1), dictated Emergency Record. On 7/23/13 at 3:45 P.M., an interview was conducted with the ED Registered Nurse (RN) 1 assigned to care for Patient 1. RN 1 stated that on 6/30/13 at about 7:30 P.M., the ED physician (MD 1) received a call informing him that Patient 1's serum potassium level was 7.0. (A normal potassium level ranges between 2.7 and 5.5). RN 1 became aware of the elevated potassium level closer to 8:00 P.M. on 6/30/13 when MD 1 ordered Kayexalate (a medication used to treat high levels of potassium in the blood) 30 Grams (gm) to be given to Patient 1 orally. RN 1 scanned the physician's order for Kayexalate to the pharmacy expecting that the pharmacy would deliver the medication to the ED. Patient 1 was being admitted to the hospital and RN 1 found out between 9:00 P.M. and 9:30 P.M. that Patient 1's inpatient bed was available. At 10:00 P.M. on 6/30/13, RN 1 transferred Patient 1 on a gurney to the inpatient nursing unit. RN 1 stated that she never called the pharmacy to follow up on the release of the Kayexalate. RN 1 never administered the Kayexalate to Patient 1 in the ED. A review of the hospital's policy and procedure entitled "Medications: Orders, Administration, and Documentation," dated 3/2013 was conducted. Per the policy, "Medications are administered in accordance with the written or electronic order of a licensed independent practitioner."		3rd Floor Action: The involved 3rd floor RN was placed on Administrative Leave and subsequent corrective action was completed between 07/12/13 and 08/02/13. Unit Education: All *3rd floor nursing* staff at Hospital B received Patient Advocacy training, to include the expectation that the physician is contacted if an ordered medication is unable to be administered to manage a critical value result (Attachment 1: Education Content and Rosters). This education was initiated on 07/03/13 and continued each shift until 100% completion. Housewide Education: This training was then implemented for all nursing staff at both campuses beginning 07/10/2013 and ongoing until 100% completion is achieved. Monitoring: A minimum of 70 scenario-based interview audits of nursing staff was conducted monthly to validate nursing staffs' understanding of the appropriate response to managing a critical value result, to include contacting the physician if the RN is unable to administer the medication ordered. (Attachment 5: Scenario Based Interview Questions) Compliance rates were reported monthly to the Quality Assurance and Performance Improvement Committee (QAPIC), where data trends were tracked and analyzed. Ongoing process or performance improvements were monitored and/or revised to ensure compliance with stated action plan. Adjustments to the frequency and scope of audits were made under the direction of QAPIC. 70213 (a) Written policies and procedures shall be developed, maintained and implemented by the nursing service.	07/23/13 08/29/13 09/10/13

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	A review of the hospital's policy and procedure entitled "Medication Administration", dated 4/2013 was reviewed. Per the policy, "Medication orders were to be scanned to the pharmacy." An interview was conducted with the RN Manager of the ED (EDRNM) on 7/25/13 at 8:45 P.M. The EDRNM stated that the Kayexalate should have been available within twenty minutes of when the order was scanned to the pharmacy. However, the pharmacy never received the scan of the physician's medication order for Patient 1. RN 1 never called the pharmacy to follow up and check on the availability of the Kayexalate. The EDRNM further explained that it was the expectation that the medication should have been administered by RN 1 within 1 hour of MD 1 writing the medication order. MD 1 wrote the order for the Kayexalate at about 8:00 P.M. on 6/30/13. Patient 1 was transferred to the inpatient nursing unit at 10:00 P.M., two hours later. During the interview with RN 1, she explained that she faxed a report regarding Patient 1 to the inpatient nursing unit prior to Patient 1's transfer. However, there was no documentation in the faxed report that the Kayexalate had not been administered. When RN 1 arrived on the inpatient nursing unit with Patient 1, RN 1 told the Charge RN that the Kayexalate had not been administered to the patient in the ED. During the interview, RN 1 stated that she thought the pharmacy would deliver the Kayexalate to the ED. RN 1 said that she should have been more aggressive by scanning the		Responsible Person: Chief Nursing and Operations Executive MD Notification of Critical Test Results – Critical Test Report Policy Immediately after the event the following actions were taken: Leadership notification occurred on 7/1/13 and the investigation was initiated, staff were interviewed and placed on administrative leave. Meetings on 7/2/13 at 8:00am, 11:30 am, 2:00pm, and 5:00 pm, and on 7/3/13 at 8:30am, 11:00am and 3:30pm, and Root Cause Analysis on 7/3/13 at 1:00pm to assess gaps in practice vs policy/best interests of patient to ensure that processes are put in place to prevent immediate risk to future patients. Education on Patient Advocacy in Critical Lab Values and Therapeutic Intervention and Professional Obligations process was initiated on 7/2/13 and was ongoing at the Chula Vista campus, Emergency Department and 3rd floors. (Attachment 1: Education Content and Rosters) Corrective Action. The three employees involved in this event were placed on administrative leave. (Attachment 2: Administrative Leave Letters) Education Expansion an audit of prior critical lab tests cases and acute renal failure management was being conducted to assess the scope of the issue and need for education. Subsequent to the event the following actions were taken: Utilizing a rapid cycle improvement methodology, a task force was formed and met to develop corrective action plan. Members included nurse managers, nurse directors, clinical informatics nurse specialist, clinical nurse specialist, director	07/31/13

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	medication order and then calling the pharmacy. RN 1 stated that a patient should not leave the ED until every physician's order has been completed. RN 1 acknowledged that did not occur. When Patient 1 arrived on the inpatient nursing unit, RN 1 gave a hand-off report (verbal exchange of information about the patient's status) to RN 2, the nurse assigned to care for Patient 1. RN 1 informed RN 2 that the Kayexalate was never administered to Patient 1 in the ED. A review of the Admission Orders, written by MD 1, revealed that there was a second physician's order for "Kayexalate 30 gm po (orally) @ 2200 hrs. (10:00 P.M.)" On 7/23/13 at 10:30 A.M., an interview was conducted with RN 2, of the inpatient nursing unit that Patient 1 was admitted to on 6/30/13 at 10:00 P.M. RN 2 stated that when Patient 1 arrived on the inpatient nursing unit, within 15 minutes, she began the admission process. At 10:59 P.M., RN 2 tried to contact Patient 1's attending physician (MD 2) by calling his number that was listed at the nursing station. MD 2 never answered, so RN 2 left MD 2 a voice mail message informing MD 2 of Patient 1's admission to the nursing unit. RN 2 asked MD 2 to call her back. RN 2 stated that she never made any further attempts to call MD 2. RN 2 explained that she found out about Patient 1 having a serum potassium level of 7.0 at about 11:30 P.M. when she reviewed the paper work that was faxed to the nursing unit from the ED regarding		of patient safety and the director of the clinical lab. A pilot program was developed. The Critical Test Result Report generated by the EMR would print on demand every 6 hours on 4 pilot units at Hospital A and 3 pilot units at Hospital B. The report would contain the previous 24 hours' worth of critical test results. The report would be reviewed by the charge nurse. The charge nurse would reconcile all nursing actions and address any critical lab test result that did not have documentation that the physician had been notified of the critical test result with the nurse who received the telephonic notification of the critical test result by the lab and/or any physician notification that was beyond 30". (Attachment 6: Sample Critical Test Report) The charge nurse contacts the bedside nurse to inquire if the notification to the physician was completed. The nurse is required to identify the actions that were taken and appropriately document. Note: The nurse may use their clinical judgment and determine that the physician does not need to be notified of the critical test result. That clinical judgment must be documented. The charge nurse reviewed report is placed in a 3 ring binder, signed and dated, and any unreconciled finding would be red circled so that the nurse supervisor/manager would be aware of any staff nurse needing coaching or counseling. See standard work instructions developed for the charge nurse. (Attachment 7: Critical Test Report Standard Work Instructions) The Emergency Department receives a report from the Clinical Lab Information System that identifies the critical lab test results for the previous 3 hours. See sample report (Attachment 8: Sample Critical Test Report ED) See standard work instructions that were developed for the Emergency Department Charge Nurses.	08/05/13 08/06/13 08/06/13

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	Patient 1. Handwritten on the ED report was "Admitted for UTI (Urinary Tract Infection) K (potassium) = 7 Renal Failure". RN 2 stated that a potassium level of 7.0 was a critical value serum potassium and needed to be reported to Patient 1's attending physician. RN 2 stated that she never called MD 2 once she was aware that Patient 1 had a critical value potassium level. Instead of informing MD 2 of Patient 1's serum potassium level she said she chose to continue monitoring the patient. Per RN 2, at 11:40 P.M. on 6/30/13, RN 2 attempted to administer the 10:00 P.M. ordered dose of Kayexalate to Patient 1. Patient 1 was restless and not cooperative; therefore, the second dose of Kayexalate, written by MD 1 in Patient 1's Admission Orders, was never administered. RN 2 stated that she informed the Charge RN that she did not administer the Kayexalate but she never informed the attending physician. The Charge RN never informed the attending physician nor did she instruct RN 2 to do so. On 7/1/13, at midnight, the Charge RN called RN 2 to inform her that the lab had called to report Patient 1's potassium level was 6.2 (still a critical value). RN 2 stated that she went to the Charge RN to find out if MD 2 had ever called back. He had not. Neither the Charge RN nor RN 2 placed a second call to MD 2. The hospital's policy and procedure, entitled "Critical Results Reporting", dated August 2012, indicated that a potassium level less than 2.7 and		(Attachment 9: Critical Test Report Standard Work Instructions) The task force met and the pilot was extended to an additional 3 units at Hospital A and the timeframe of the report was shortened to 12 hours. An executive committee meeting including the Chief Executive, the Clinical Lab Director, the Quality Director, the Chief of Staff and the Pathology Medical Directors. The Critical Test Result policy was amended so that the definition of repeat critical test results was made clearer, critical language would be used by laboratory personnel when notifying a nurse of a critical test result and the Lab would always notify the nurse of a critical test result (MD could be notified as well). (Attachment 10: Revised Critical Result Policy) The policy was officially approved by the Medical Executive Committee. Task force met and reviewed preliminary data. The Emergency Department critical test result was changed to review the previous 4 hours and began to be sent via email to each ED charge nurse. The decision was made to extend the pilot to an additional 2 units at Hospital B. Task force met and determined that the pilot was successful and all remaining units at both Hospitals went live effective August 21, 2013. Formal education on the revised quality control process for critical test result reporting was distributed to all Registered Nurses via the Learning Management System. Monitoring: A minimum of 70 critical test lab results were evaluated monthly using the attached audit tool. (Attachment 11: Critical Test Results Audit)	08/21/13 08/20/13 08/20/13 08/21/13

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	greater than 6.0 is considered a "critical result". The policy defined a "critical result" as "Those values/interpretations that indicate that the patient is in imminent danger of death, significant morbidity, or serious adverse consequences unless evaluated immediately. Critical results may be the value/finding of a test that was ordered routinely." During the interview with RN 2, on 7/23/13 at 10:30 A.M., RN 2 stated that she should have made multiple attempts to call MD 2 regarding Patient 1's critical value serum potassium level. In addition, RN 2 acknowledged that she should have advocated for the patient by calling the Operations Supervisor regarding Patient 1's critical potassium level and to inform the Operations Supervisor that MD 2 had not responded to her call. Further review of the hospital's policy and procedure entitled "Critical Results Reporting", dated August 2012, indicated that "Responsibilities...Results reported to the Licensed Responsible Caregiver (RN): 1. Write down critical result, date and time. 2. If phone report, provide read back to verify reported result. 3. Notify appropriate physician or designee of critical result and document physician name, date, and time in the medical record. The licensed responsible caregiver will attempt to contact the physician at a minimum of 15 minute intervals up to 30 minutes. If the physician has not responded to		Compliance rates were reported monthly to the Quality Assurance and Performance Improvement Committee (QAPIC), where data trends were tracked and analyzed. Ongoing process or performance improvements were monitored and/or revised to ensure compliance with stated action plan. Adjustments to the frequency and scope of audits were made under the direction of QAPIC. 70213 (d) Policies and procedures that require consistency and continuity in patient care, incorporating the nursing process and the medical treatment plan, shall be developed and implemented in cooperation with medical staff. Chain of Command Policy Responsible Person: Chief Nursing and Operations Executive Immediately after the event the following actions were taken: Leadership notification occurred on 7/1/13 and the investigation was initiated, staff were interviewed and placed on administrative leave. Meetings on 7/2/13 at 8:00am, 11:30 am, 2:00pm, and 5:00 pm, and on 7/3/13 at 8:30am, 11:00am and 3:30pm, and Root Cause Analysis on 7/3/13 at 1:00pm to assess gaps in practice vs policy/best interests of patient to ensure that processes are put in place to prevent immediate risk to future patients. Education on Patient Advocacy in Critical Lab Values and Therapeutic Intervention and Professional Obligations process was initiated on 7/2/13 and was ongoing at the Chula Vista campus, Emergency Department and 3rd floors. (Attachment 1: Education Content and Rosters) Corrective Action. The three employees involved in this event had been placed in Administrative	

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	notification within 30 minutes, the licensed responsible caregiver will follow the normal chain of command for critical clinical communication i.e. charge nurse, manager or Operation Supervisor. An interview was conducted with the Chief Nursing and Operations Executive (CNOE) on 7/23/13 at 11:15 A.M. The CNOE stated that the expectation regarding the nurses' responsibility for critical lab values was to contact the MD immediately. If the MD did not respond the nurse should use the chain of command up to the Chief of Staff to address the patient's critical lab value. The CNOE further explained that the RN was the patient's representative. Patient 1 was vulnerable and had a very high potassium level. RN 2 should have advocated for Patient 1 to get medication orders from an MD to lower her potassium level. However, that did not occur. A review of the hospital's policy and procedure entitled "Chain of Command", dated July 2013, indicated that "In the event a patient care staff member has experienced a clinical issue involving the appropriateness of a physician's management of patient care and are not successful in resolving the issue directly with the physician(s) of record, the following steps will be followed: 1. Staff member to inform the Charger Nurse, Manager/Supervisor of the unit, or if after hours or weekends, call the Operations Supervisor. 2. The Manager or Supervisor will assess the patient issue and call the physician to discuss.		Leave. (Attachment 2: Administrative Leave Letters) Chain of Command Policy Subsequent to the event the following actions were taken: The involved RN was placed on investigatory leave. Subsequent corrective action was completed between 07/12/13 and 08/02/13. All 3rd floor nursing staff at Hospital B received Patient Advocacy training, to include the expectation that the chain of command is initiated if a physician does not return phone calls (Attachment 1: Education Content and Rosters) This education was initiated on 07/03/13 and continued each shift until 100% completion. Patient Advocacy training was then implemented for all nursing staff at both campuses beginning 07/10/13 and ongoing until 100% completion was achieved. Monitoring: A minimum of 70 scenario-based interview audits of nursing staff were conducted monthly to validate nursing staffs' understanding of the chain of command process. (Attachment 5: Scenario Based Interview Questions) Compliance rates were reported monthly to the Quality Assurance and Performance Improvement Committee (QAPIC), where data trends were tracked and analyzed. Ongoing process or performance improvements were monitored and/or revised to ensure compliance with stated action plan. Adjustments to the frequency and scope of audits were made under the direction of QAPIC.	07/01/13 07/23/13 08/29/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050077	A. BUILDING _____ B. WING _____	07/30/2013

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	3. If the issue cannot be resolved between the Manager/Supervisor and physician, the Manager/Supervisor is responsible for following both the medical chain of command (see below) and the nursing chain of command (Manager > Director > Assistant Administrator > CNOE (Chief Nursing Operating Executive). Chain of Command Flow Chart - Medical Management Patient Issue > Call Physician > Notify Manager or Operations Supervisor > Contact Physician. If unresolved or if MD is unavailable, call Chief of Department In the event the Supervisor is unable to reach the Chief of the Department, the Chief of Staff, Chair of the Physician Leadership Cabinet (Hospital B only) or Senior Director of Medical Affairs should be contacted. The Operations Supervisor will maintain a current list of contact information for these individuals." On 7/1/13 at 6:56 A.M. the lab called and informed RN 2 that Patient 1's serum potassium was 7.6. During the interview with RN 2, on 7/23/13 at 10:30 A.M., she explained that at 7:00 A.M. on 7/1/13, she received a call from the Telemetry Technician (A technician who was continuously monitoring Patient 1's heart rhythm). The technician informed RN 2 that Patient 1's heart rate was in the 40's with long pauses in between each beat. RN 2 went to Patient 1's room. Patient 1 was unresponsive and			

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	breathing very slowly. Patient 1's heart rate then went down to the 30's and 20's (a normal heart rate is 60 to 100 beats per minute). At first RN 2 called for the Rapid Response Team (rapid intervention for patients that are quickly deteriorating) but then quickly called a Code Blue (a team of medical personnel work to revive a patient in cardiac arrest) because the patient's condition had deteriorated. The Code Blue was unsuccessful. Patient 1 was pronounced dead on 7/1/13 at 7:30 A.M. A review of Patient 1's Autopsy Report, dated 7/9/13, listed the following clinical diagnoses at the time of Patient 1's death: 1. Cardiac Arrest Secondary to Severe Hyperkalemia 2. Acute Renal Failure 3. Urosepsis (an infection of the blood caused by a urinary tract infection) 4. Diabetes Mellitus 5. Possible UGI (upper gastro-intestinal) Bleed The facility's noncompliance with these requirements, jointly, separately or in any combination, has 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 1280.1.			

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