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
	050243	A. BUILDING _____ B. WING _____	07/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT REGIONAL MEDICAL CENTER	1150 N Indian Canyon Dr, Palm Springs, CA 92262-4872 RIVERSIDE COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00438857 - Substantiated Representing the Department of Public Health: Surveyor ID # 1977, 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. The Department was able to substantiate the allegations. Deficiencies were issued for complaint number CA00438857. Health and Safety Code section 1280. (3) (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 1250for 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		**The plan of correction is prepared in compliance with federal regulations and is intended as Desert Regional Medical Center's (the "hospital") credible evidence of compliance. The submission of the plan of correction is not an admission by the facility that it agrees that the citations arc correct or that it violated the law.** **Policy & Procedures:** The Chief Nursing Officer and the Director of Clinical Quality Improvement reviewed without revisions the policy titled, Surge Plan: Alpha, Bravo, Charlie. The policy defines the placement of patients during a sudden increase in census. The Governing Board approved the revisions to the policy titled, Critical Results/Values and Reporting (Adult) that includes the one-hour time frame requirements for notification to the physician.	6/29/15 10/5/15

Event ID:TZYX11 7/25/2017 12:22:35PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE CEO (X6) DATE 8-10-17

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 11

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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	hundred twenty-five thousand dollars ($125,000) 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. California Code of Regulations, title 22, section 70215 (a)(2) and (b): (a) A registered nurse shall directly provide: (2) The planning, supervision, implementation and evaluation of the nursing care provided to each patient. (b)The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission. California Code of Regulations, title 22, section 70243(f)(1) (f) The director of the clinical laboratory shall ensure that: (1) Examinations are performed accurately and in a timely fashion. On April 29, 2015, at 9:20 a.m. an unannounced		The Laboratory Director revised the policy and procedure titled, Blood Storage in the Emergency Department's Trauma Refrigerator. 4/10/2015, however the policy was not in effect as the blood refrigerator was removed. The policy was reviewed and approved by the Laboratory Medical Director prior to reinstituting the blood refrigerator in the Trauma ED area. The Laboratory Medical Director reviewed without revision the policy titled, Transfusion Service Agreement. Under the direction of the Laboratory Director the Blood Bank Supervisor revised the policy titled, Transfusion Service Agreement to include specificity regarding turnaround times when orders are received for a type and screen and blood transfusion. The revisions were approved by the Laboratory Medical Director.	4/10/15 3/29/17 5/18/16 7/26/17

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	visit was conducted at the facility to investigate a complaint regarding a patient (Patient 1), who died in the Interventional Radiology (IR) holding area where patients are put when there is no room remaining in the Emergency Department (ED). Patient 1 presented to the ED on March 31, 2015, with complaints of abdominal and back pain. The ED drew blood and found out that Patient 1's hemoglobin was low. The physician ordered a blood transfusion. The RN caring for Patient 1 failed to communicate critical lab results to the physician immediately, and administer a blood transfusion for one and a half hours after being informed the blood was ready. Based on interview, and record review, the Department determined that the facility failed to provide Patient 1 with necessary care and services, including but not limited to: 1. Failure to notify the Patient 1's physician of critically low hemoglobin for one and one half hours, pursuant to the policies and procedures. 2. Failure to follow up and ensure the blood transfusion ordered by the physician was started in a timely manner. 3. Failure of the Director of the Clinical Laboratory (DCL) to ensure laboratory tests were performed in a timely manner when a type and crossmatch (a laboratory test to check for blood-type) was performed and a compatible unit of blood was administered in a timely manner for Patient 1. These failed practices resulted in a delay in a blood transfusion being started, and contributed in the		The Laboratory Director and/or Manager as well as the Laboratory Medical Director reviewed without revisions the policy titled, Blood Bank Collect Specimen Collection & Handling. The Laboratory Director and/or Manager as well as the Laboratory Medical Director reviewed without revisions the policy titled, Verbal Requests. The Interim Accreditation & Licensing Manager reviewed without revisions the Governing Board Rules and Regulations. Article VIII Section 5 discusses the requirements "to implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care, for identifying opportunities to improve patient care, and for identifying and resolving problems."	5/11/15 5/18/16 7/19/17 5/18/16 8/4/17 8/8/17

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	death of Patient 1. Findings: During a confidential interview with facility staff, on April 29, 2015, the staff stated a Patient 1 had recently died in the IR holding area, and she was concerned about patient safety at the facility. The record for Patient 1 was reviewed on June 16, 2015. Patient 1 presented to the ED on March 31, 2015, at 9:35 p.m. with complaints of abdominal and back pain. During Patient 1's ED stay, blood was drawn at 10 p.m., and her hemoglobin result was 7.9 g/dl (grams/deciliter) (low - normal value is 11.5 - 15.0 g/dl). [Hemoglobin is an iron rich protein in the red blood cells that carries oxygen from the lungs to the rest of the body. Anemia can occur if your red blood cells don't contain enough hemoglobin.] On April 1, 2015, Patient 1 was admitted from the ED at 6:32 a.m. as an inpatient with diagnoses that included back pain, hypoxia (low oxygen level), and anemia. The nurse's notes indicated Patient 1 was admitted to the IR holding area, bed 1, at 6:32 a.m. The IR holding area is an area that was licensed to be used for patients to wait prior to having an interventional radiology procedure. However, at the time of Patient 1's admission, it was being used as an overflow area to house admitted patients while they were awaiting an open licensed, inpatient bed in the hospital unit		The Chief Nursing Officer and the Director of Clinical Quality Improvement reviewed without revisions the policy titled, Surge Plan: Alpha, Bravo, Charlie. The policy defines the placement of patients during a sudden increase in census. **Education/Training** Blood administration and critical value procedures education are provided to the nursing staff at initial orientation and continues annually. The Nursing Education department, under the direction of the Chief Nursing Officer provided Blood Administration education to nurses who participate in administration of blood via the .edu electronic system. The education will be given at initial orientation and repeated at re-orientation annually.	6/29/15 7/2015 12/31/15 12/31/17

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	they were admitted to. According to the notes, the patient was made aware that she was being admitted to, "an overflow area," and when a bed was available for her on another unit, she may be transferred there. Patient 1's medical record indicated the following occurred on April 1, 2015: At 8 a.m., the physician was at the bedside to see Patient 1, and repeat blood tests were ordered (at 7:54 a.m.); At 9:15 a.m., blood was drawn by the laboratory, for the blood tests; At 10:22 a.m.,(one hour and 7 minutes after the lab drew the blood) a critical value (hemoglobin of 6.7 - critically low according to the hospital reference range) was called to RN 1 (who was caring for Patient 1) by the laboratory; At 12 noon (one hour and 38 minutes after the RN was notified of the critical value), RN 1 notified the physician of the critically low hemoglobin; At 12:06 p.m., a unit of blood was ordered by RN 1; At 2:25 p.m. (two hours and 19 minutes after the unit of blood was ordered for a critically low hemoglobin), blood was drawn from the patient, by the lab [in this case the lab drew the blood patient because the patient was admitted to the hospital but located in an observation bed because no beds were available on the floor], and the blood was then		The clinical Educator for the Emergency Department (ED) provided education to the Emergency Room Staff responsible for the ED Trauma Refrigerator Guidelines. The Blood Bank Supervisor provided training to the applicable laboratory staff. The education included but was not limited to: Emergency Blood Release, Blood in the ED, Massive Transfusion Protocol, Responding to Alarms and the Helmer refrigerator. The Phlebotomy Supervisor and the Blood Bank Supervisor will provide education to applicable laboratory staff regarding the laboratory process for drawing blood from patients located in the overflow holding areas, the timeliness of specimen collection and expectation for correct and complete orders.	5/25/17 3/28/17 9/15/17

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	delivered to the blood bank. At 3:09 p.m. (three hours and three minutes after the unit of blood was ordered), a type and screen order was entered by the blood bank (to begin the process of testing the blood that had been drawn, and finding a suitable unit of blood to transfuse). At 4 p.m. (five hours and 38 minutes after the nurse learned of a critically low hemoglobin, and three hours and 54 minutes after the unit of blood was ordered to be transfused), RN 1 obtained a consent from Patient 1 for a blood transfusion, and notified the physician he had to come in and sign the consent; At 4:01 p.m., (three hours and 55 minutes after a unit of blood was ordered for a critically low hemoglobin), the blood bank notified RN 1 the unit of blood was ready to be picked up and transfused; At 5 p.m. (six hours and 38 minutes after the reported critically low hemoglobin, and four hours and 54 minutes after the unit of blood was ordered to be transfused), the consent was signed by the physician; and; At 5:30 p.m., (five hours and 24 minutes after a unit of blood was ordered) (seven hours and eight minutes after the reported critically low hemoglobin), RN 1 started the blood transfusion. According to the nurse's notes, at 5:33 p.m. (three minutes after the transfusion was started), Patient 1 became unresponsive, and the blood transfusion		The Director of Clinical Quality Improvement and Education provided education to the Patient Safety Officer and the Interim Accreditation & Licensing Manager provided education to the Administrative Assistant regarding the reporting requirements for adverse advents including but not limited to the flow of information from the Patient Safety Committee to the Governing Board. The Assistant Chief Nursing Officer provided education to the House Supervisors regarding the expectations that "If IR/Overflow is being opened or closed, ensure we are following the policy and the Administrator On Call, ACNO and CNO are being contacted. Times of opening and closing should be included in the report". The Director of the One Call Center provided education to the One Call staff regarding the notification of admissions and discharges to the overflow units to the Clinical Laboratory and Blood Bank, Pharmacy, Radiology, Food and Nutrition, Environmental Services, Infection Prevention, Physical Therapy and Respiratory Therapy.	8/7/17 4/3/15 7/14/15

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	was stopped. At 5:35 p.m. (two minutes later), she did not have a pulse. CPR was started, and a code blue was called. A phone interview was conducted with RN 1 on December 9, 2015, at 3:30 p.m. RN 1 stated she was the primary nurse for Patient 1 on April 1, 2015. She stated critical lab values were to be called to the physician and documentation of the call would be put on the nurse's notes or under the physician communication section in the clinical record. She stated if she had notified the physician of a critical lab value, she would document as doing so. RN 1 stated "I would hope documentation was there." There was no evidence in the patient's medical record to indicate RN 1 documented receiving the critical lab value or that she notified the physician of the critical lab value. Review of the Blood Bank Transfusion Reaction Evaluation form, dated April 1, 2015, at 6:15 p.m., "1. No Transfusion Reaction. 2. Workup of blood type and unit indicate the blood was of appropriate type and could be continued if the patient had not expired," was noted. The dictated report from the physician who responded to the code blue (MD 1) indicated the following: "I responded to a code blue in the IR holding...an 88 year old female who had been admitted last night...when arriving on scene, the patient was bradycardic and receiving CPR...the patient had a		**Other Correction Actions:** The Trauma Blood Refrigerator was removed from the ED and is no longer in use. The Trauma Blood Refrigerator was placed back into service in the ED Trauma area. The Phlebotomy Supervisor created verbal expectations for lab drawing and location of patients that is/are in the overflow holding areas. The Phlebotomy Supervisor created guidelines for the laboratory process for drawing blood from patients located in the overflow holding areas. The Blood Bank Supervisor will create guidelines regarding the incorrect/incomplete orders.	8/2015 4/3/17 7/2015 9/15/17 9/15/17

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	hemoglobin of 6.7 at 9:00 in the morning...blood had been ordered...at about 6:00 p.m., the blood was started and within a few seconds of starting the blood, the nurse noted the patient to be bradycardic (low heart rate) and hypotensive (low blood pressure)...she determined this may be a transfusion reaction, so she stopped the transfusion...shortly thereafter, code blue was called...there was no evidence of rash or airway obstruction...it was (MD 2) and my impression that the patient probably had hemorrhagic shock with chronic GI (gastric) blood loss, anemia, and now life-threatening anemia...we ordered more blood for the patient, but could not get it from the blood bank...the patient had 2 peripheral (arms) IVs...I started a triple-lumen catheter in order to be able to get central access and give the patient more fluid resuscitation more rapidly...unfortunately, because of the inability to get blood, I just provided more hemodilution (watering down the circulating blood)...after doing this for about 50 minutes, (MD 2) and I decided that the patient may have already sustained significant brain injury and since we could not obtain blood, that further CPR was futile and the patient was pronounced dead." The facility policy titled, "Critical Results, Reporting, Critical Values (Adult)," with a revised date of October 18, 2014, was reviewed on June 25, 2015. The policy indicated the following: "Purpose: It is the policy of ...(name of facility) that critical results of diagnostic tests will be communicated in a defined systematic manner to the responsible physician , or designee, by the		The Director of Clinical Quality Improvement developed a process to report performance improvement activities related to adverse events flowing through the Patient Safety Committee, the Hospital and/or Medical Staff Quality Council, Medical Executive Committee and Governing Board of Directors. The Chief Executive Officer (CEO) also reported advents directly to the Governing Board during the CEO report. Under the Direction of the Chief Nursing Officer the "One Call Center" began faxing a communication form to the following clinical areas each time there is an admission or discharge to an overflow unit. Areas include: Clinical Laboratory and Blood Bank, Pharmacy, Radiology, Food and Nutrition, Environmental Services, Infection Prevention, Physical Therapy and Respiratory Therapy.	8/20/15 9/2015 7/13/15

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	respective diagnostic test department. The purpose of this policy is to provide a mechanism for the rapid communication of critical values in adult patients to the patient's caregiver, in order to improve the effectiveness of communication among caregivers. Definitions: Critical results were defined as abnormal values and/or test results that had been determined to be of such a serious nature that they required immediate notification of caregivers and prescribers; Procedure: All values considered to be a critical value, based on the approved Critical Values List (s), are to be called immediately to the appropriate licensed care provider upon verification of results. D. 3. If the person receiving the report (from the lab) was not the physician, he/she would immediately attempt to report the result to the appropriate physician. Nursing: i. Upon notification of a critical test result, the nurse will document utilizing the Critical Value Order Sheet, the date, time, patient's name, name of person who called the result to the nurse and the critical value. iii. The nurse shall call the ordering physician within one hour unless the physician has already addressed the critical value(s) with written treatment parameters. Critical Values/Results Tables: Hemoglobin (gm/less than 7.0 dl)." In an interview on June 22, 2015, at 1:40 p.m., the Interim Lab Director (ILD) stated that he had only		The overflow patients in the One Central are now seen in the PBAR and PASS modules of Cerner (electronic medical record). These patients will now be visible on the Census Report. The Interventional Radiology Holding area is no longer being used as overflow area for ICU patients. The California Department of Public Health is notified in writing daily, via facsimile, when the overflow units are utilized. This correspondence includes, but not limited to, the date, approximately time of the use of the unit as an overflow, the number of patients, patients names, rooms numbers and assigned staff. This practice has continued and is currently in place.	7/27/15 4/2015 6/2015 8/2017

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	been at the facility since December 1, 2014, and he did not know the policies and procedures regarding handling the blood in the lab. The ILD stated , "My role here is as an administrative director, not as a person on the bench." According to the ILD, he did not have any clinical responsibilities. The ILD stated "(I) don't have a blood bank supervisor currently. We are recruiting for one." Regarding Patient 1, the ILD stated the unit of blood was not ordered "STAT" (immediately), or it would have been drawn within 30 minutes. He stated the staff were often unable to locate patients in the hospital when they were not admitted to actual inpatient beds, so that may have caused the delay in the blood bank getting a unit of blood ready for transfusion. He stated that he was "an administration expert and not a blood bank or lab expert." During a phone interview with RN 1, conducted on December 9, 2015, beginning at 3:30 p.m., RN 1 stated she should not have waited for the physician to sign the (blood transfusion) consent. She stated she should have had another critical care physician sign it (the consent). On December 9, 2015, beginning at 2:45 p.m., MD 1 was interviewed. MD 1 stated when he arrived at the code blue, he learned the patient was getting blood, but it was stopped when her heart slowed down because the nurse thought she was having a reaction to it. He stated he and the other physician responding to the code blue believed Patient 1 did not have a transfusion reaction, but was		**Monitoring:** The Director Clinical Quality Improvement or qualified designee will continue to monitor the average time of notifying the physician by nursing when a critical lab value is resulted. The nurse must notify the physician within 60 minutes upon receiving the critical lab value. The results will be reported to the Hospital Quality Council, Medical Executive Committee and Governing Board quarterly for review and action as required. The Quality Department will continue monitoring a representative sample size of patients who receive a blood transfusion for the following: compliance to the Blood Administrative policy, physician orders, nursing documentation, informed consent and appropriateness (justification) of the blood products. The Trauma Blood Refrigerator is connected to an outside vendor to monitor the alarms; also the alarm can be heard by the ED staff. If the blood refrigerator alarms the vendor contacts the laboratory directly for investigation and clearance of the alarm. In addition, the Blood Bank Supervisor or designee records the alarms and reason for the alarm on the ED Blood Storage Refrigerator Alarms log.	

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	experiencing hypovolemia (low blood volume). MD 1 stated they (the two physicians) wanted to give her blood, but they could not because the patient had been, "labeled as having a transfusion reaction." He stated the delay in treating Patient 1 (with a blood transfusion), was a contributing factor," in her death. Failure of RN 1 to advocate on behalf of Patient 1, reporting the critical hemoglobin value immediately to the physician and communicating with the laboratory to expedite the start of the blood transfusion, resulted in a significant delay in starting the transfusion and may have resulted in the death of Patient 1. The facility failed to ensure its nursing and laboratory staff provided timely services and treatment to Patient 1. These deficiencies caused, or are likely to cause serious injury or death to a patient, and therefore constitute an immediate jeopardy within the meaning of Health and Safety Code section 1280.3 (g).		The Laboratory Director or designee periodically compares the vendor system Event Report and the manual log for completion. The Phlebotomy Supervisor and the Blood Bank Supervisor will monitor adherence to the Guidelines for lab drawing from patients located in the overflow holding areas and incorrect/incomplete orders. The compliance will be reported to the Laboratory Medical Director and Laboratory Director. The Chief Executive Officer will ensure adverse events, including a brief description, are reported to the Governing Board on a regular basis. The One Call Center Manager monitored the placement of 100% of the overflow patients in PBAR and PASS into the correct nursing station and room number for all patients in the 1 Central Unit for the first month. Immediate action will be taken to correct any issue with the One Call Center staff. This monitoring occurred for 3 months in which 100% compliance was met.	10/31/15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT REGIONAL MEDICAL CENTER	1150 N Indian Canyon Dr, Palm Springs, CA 92262-4872 RIVERSIDE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	experiencing hypovolemia (low blood volume). MD 1 stated they (the two physicians) wanted to give her blood, but they could not because the patient had been, "labeled as having a transfusion reaction." He stated the delay in treating Patient 1 (with a blood transfusion), was a contributing factor," in her death. Failure of RN 1 to advocate on behalf of Patient 1, reporting the critical hemoglobin value immediately to the physician and communicating with the laboratory to expedite the start of the blood transfusion, resulted in a significant delay in starting the transfusion and may have resulted in the death of Patient 1. The facility failed to ensure its nursing and laboratory staff provided timely services and treatment to Patient 1. These deficiencies caused, or are likely to cause serious injury or death to a patient, and therefore constitute an immediate jeopardy within the meaning of Health and Safety Code section 1280.3 (g).		**Responsible Person(s):** Governing Board Chief Executive Officer Chief Medical Officer Chief Nursing Officer Administrator on Call Assistant Chief Nursing Officer Director of One Call Center Director of Clinical Quality Improvement & Education Patient Safety Officer Laboratory Medical Director Laboratory Director Emergency Services Director Blood Bank Supervisor **Disciplinary Action:** Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.	