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 _____	11/01/2017

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: CA00451429, CA00451880 - 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. A 009 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 rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgement on drug selection and dose. Pharmaceutical Services General Requirements, Title 22, Division 5, Chapter 1, Article 3, Section		The attached Plan of Correction is submitted for your review and approval. POC acceptable 12/12/17 TB (attached)	

Event ID:IOAR11 11/14/2017 3:58:29PM

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

Thomas J. Santos, RN, CQO December 11, 2017

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 14

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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	70263(g)(2): (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 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. Nursing Staff Development, Title 22, Division 5, Chapter 1, Article 3, Section 70214 (a)(2)(A): (a) There shall be a written, organized in-service education program for all patient care personnel, including temporary staff as described in subsection 70217(m). The program shall include, but shall not be limited to, orientation and the process of competency validation as described in subsection 70213 (c). (2) All patient care personnel, including temporary staff as described in 70217(m), shall be subject to			

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	the process of competency validation for their assigned patient care unit or units. Prior to the completion of validation of the competency standards for a patient care unit, patient care assignments shall be subject to the following restrictions: (A) Assignments shall include only those duties and responsibilities for which competency has been validated. Nursing Service Staff, Title 22, Division 5, Chapter 1, Article 3, Section 70217(a): (a) Hospitals shall provide staffing by licensed nurses, within the scope of their licensure in accordance with the following nurse-to-patient ratios. Licensed nurse means a registered nurse, licensed vocational nurse and, in psychiatric units only, a licensed psychiatric technician. Staffing for care not requiring a licensed nurse is not included within these ratios and shall be determined pursuant to the patient classification system. No hospital shall assign a licensed nurse to a nursing unit or clinical area unless that hospital determines that the licensed nurse has demonstrated current competence in providing care in that area, and has also received orientation to that hospital's clinical area sufficient to provide competent care to patients in that area. The policies and procedures of the hospital shall contain the hospital's criteria for making this determination. Licensed nurse-to-patient ratios represent the maximum number of patients that shall be assigned to one licensed nurse at any one time. "Assigned" means the licensed nurse has responsibility for the provision of care to a particular patient within his/her			

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	scope of practice. There shall be no averaging of the number of patients and the total number of licensed nurses on the unit during any one shift nor over any period of time. Only licensed nurses providing direct patient care shall be included in the ratios. Nurse Administrators, Nurse Supervisors, Nurse Managers, and Charge Nurses, and other licensed nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those licensed nurses are engaged in providing direct patient care. When a Nurse Administrator, Nurse Supervisor, Nurse Manager, Charge Nurse or other licensed nurse is engaged in activities other than direct patient care, that nurse shall not be included in the ratio. Nurse Administrators, Nurse Supervisors, Nurse Managers, and Charge Nurses who have demonstrated current competence to the hospital in providing care on a particular unit may relieve licensed nurses during breaks, meals, and other routine, expected absences from the unit. Licensed vocational nurses may constitute up to 50 percent of the licensed nurses assigned to patient care on any unit, except where registered nurses are required pursuant to the patient classification system or this section. Only registered nurses shall be assigned to Intensive Care Newborn Nursery Service Units, which specifically require one registered nurse to two or fewer infants. In the Emergency Department, only registered nurses shall be assigned to triage patients and only registered nurses shall be assigned to critical trauma patients. Nothing in this section shall prohibit a licensed nurse from assisting with specific tasks within the scope of his or her practice for a patient assigned to			

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	another nurse. "Assist" means that licensed nurses may provide patient care beyond their patient assignments if the tasks performed are specific and time-limited. Based on observation, interview, and record review, the facility failed to provide safe and effective medication administration as follows: 1 a. Medications were not given as ordered, when a physician's order for one patient (Patient 1) indicated he should receive insulin based on a sliding scale (giving varied amounts of insulin depending on what the patient's blood sugar was). The medication administration record (MAR), was inaccurately transcribed by the pharmacy and indicated an insulin dose was to be given four times a day, regardless of what the patient's blood sugar was; 2a. Lack of consistent criteria was applied to orientation, training, and competency verification for one Registered Nurse (RN 1), when she was oriented for four weeks, then assigned to care for one patient (Patient 1) without definitive evidence she had demonstrated competency to care for him; and 2b. The Registered Nurse (RN 1) failed to administer insulin as ordered and failed to follow nationally recognized standards of practice regarding the insulin double check process (having two RNs check the insulin dose prior to administering it to prevent a medication error).			

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	Together these failures resulted in the patient receiving 100 units of insulin for a blood sugar of 124 (normal with no insulin needed) which caused life threatening hypoglycemia (low blood sugar), a transfer to the Intensive Care Unit (ICU) on a ventilator (breathing machine), and had the potential to result in the patient's death. Findings: The clinical record for Patient 1 was reviewed on July 23, 2015. Patient 1, an 80 year old male, was admitted to the facility on July 13, 2015, with diagnoses that included anemia and diabetes. The physician's admission order dated July 13, 2015, indicated "Finger stick Glucose: Before each meal and at bedtime (AC&HS) (use) Novolog Insulin Sub-Q (under the skin) (Fast Acting)." The "Insulin Sliding Scale Orders," dated July 13, 2015 at 10:00 p.m., indicated: No insulin for a blood sugar less than 200, For a blood sugar of 201-250, give 2 units of Novolog insulin; For a blood sugar of 251-300, give 3 units of Novolog insulin; For a blood sugar of 301-350, give 4 units of Novolog insulin; For a blood sugar of 351-400, give 5 units of Novolog insulin; For a blood sugar of 401-449, give 6 units of Novolog insulin; and,			

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If the blood sugar was greater than 450, give 7 units of Novolog insulin and call the physician."

A physician's order, dated July 20, 2015 at 6:51 p.m., indicated, "Clarification of order for accuchecks (glucose checks-measuring amount of sugar in the blood)... Begin every q2h (two hours) glucose checks when patient is called to OR (operating room). Continue q2h accuchecks until back from recovery & alert. Hold Lantus (longer acting type of insulin) until awake. Use Novolog (fast acting type of insulin) sliding scale q4h (four hours)."

A review of Patient 1's MAR dated July 20, 2015, revealed the facility pharmacist had incorrectly transcribed the physician's order dated, July 20, 2015. Further review of the MAR revealed that a scheduled insulin dose of 100 units of Novolog insulin was to be given to Patient 1 at 7 a.m., 11 a.m., 3 p.m., and 7 p.m., in addition to sliding scale coverage, depending on the glucose level when it was checked, every four hours. However, a review of Patient 1's clinical record revealed that there was no physician order to give the patient 100 units of insulin every four hours as indicated on the MAR.

The order for insulin was inaccurately documented on the MAR as follows:

"Novolog 1 UNIT/0.01 ML (milliliter)...DOSE: 100 UNIT/1 ML EVERY 4 HOURS Drug Notes: PATIENT MUST HAVE MEAL TRAY PRIOR TO NOVOLOG

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	ADMINISTRATION!! HIGH ALERT MEDICATION LOOK/SOUND ALIKE DOUBLE CHECK WITH 2ND RN" Review of the MAR indicated RN 1 and RN 2 both signed the MAR indicating the patient was given 100 units of Novolog insulin on July 21, 2015, at 7 a.m. The MAR indicated at 7:30 a.m., Patient 1's blood sugar was 124. According to the physician's order for the sliding scale coverage, the patient should not have received any insulin for a blood sugar of 124. A review of the nurse's notes dated July 21, 2015, indicated the following: At 7:50 a.m., the patient was lying in his bed, alert and oriented, with no signs of distress or pain; At 10 a.m., the patient was lethargic and unresponsive, and his physician was paged; At 11 a.m. the patient's blood sugar was 21 (critically low: normal 80-100). At 11:25 a.m., the patient was using accessory muscles to breathe (difficulty breathing), he was not responding to touch or stimulation, and RN 1 gave 25 grams of dextrose (to increase his blood sugar); At 11:40 a.m., the patient's blood sugar had increased to 103, but he remained unresponsive to stimulation; Upon rechecking the blood sugar (no time documented), the blood sugar had dropped to 59, additional nurses were called for assistance, a			

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rapid response team (emergency response team) was called, the patient was intubated (a breathing tube was inserted), and he was transferred to the ICU.

The physician responding to the emergency call on July 21, 2015, at 12:30 p.m., documented he found the patient unresponsive with decerebrate posturing (involuntary extension of the arms and legs indicating severe brain injury).

A neurology consult, completed July 22, 2015, indicated an electroencephalogram (EEG - brain wave test) showed slowing of the brain and seizure-like activity. The neurologist indicated Patient 1 was in a transient (temporary) coma, and had hypoglycemic encephalopathy (damage to or malfunction of the brain caused by low blood sugar), and seizures due to the encephalopathy.

During an interview with the facility Risk Manager (RM) on July 23, 2015, at 9:45 a.m., the RM stated when she interviewed RN 1, RN 1 demonstrated how she administered the insulin, and had it doubled checked by RN 2.

According to the RM, when she spoke to RN 2 (who double checked Patient 1's insulin dose and signed off on it), RN 2 repeatedly stated she did not remember details, but, "it matched," referring to the insulin double check. The RM stated RN 2, "turned white," when she realized 100 units of Novolog had been given to the patient, and she told the RM that was not an appropriate dose to give.

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During a telephone interview with RN 1, on July 23, 2015, at 10:45 a.m., RN 1 stated she took care of Patient 1 early in his admission, and his blood sugars were, "out of control." She stated they were up into the 400's, so when she saw the scheduled insulin dose of 100 units to be given four times a day, she, "figured," that was the solution they came up with to control his blood sugars.

RN 1 stated when she checked Patient 1's blood sugar the morning of July 21, 2015, his sugar was 124, and no sliding scale coverage was needed, so she didn't give any extra insulin. She stated she only gave what was scheduled at 7 a.m. (100 units, according to the MAR), and she had a second nurse (RN 2) double-check the dose before administering it.

RN 1 stated she checked Patient 1 at 10 a.m., he was lethargic and unresponsive. According to the nurse, a sitter who was with the patient reported that he fell asleep at approximately 8:30 a.m. RN 1 stated she called Patient 1's physician to report his condition. She stated she rechecked his blood sugar at 11 a.m. (when the next scheduled dose of insulin was due), and the result was 21. According to the nurse, she gave intravenous dextrose (a sugar based fluid) and summoned a colleague to assist in assessing the patient, then called a rapid response (calling for a specially trained team when a patient is in need of treatment for a life threatening event).

During an interview with the Director of Pharmacy (DOP) on July 23, 2015, at 11:10 a.m., the director stated he was aware of the medication error, and

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	had reviewed the record. He stated he identified, "multiple failure points," including: a. Order entry, the dose of insulin was incorrect as entered by the pharmacist; b. Order entry, the insulin was entered as a scheduled medication instead of a sliding scale dose by the pharmacist; c. Nursing accepted the order when they noted it; d. The nurse did not question the (potentially fatal) dose before giving the insulin; and, e. The "whole EMR (electronic medical record) set up," and the inability to have the MAR reflect the physician's orders accurately. The DOP stated the pharmacist used, "bad judgement," when she entered the order as, "scheduled." He stated at one point the patient was getting accuchecks every two hours, before meals, and at bedtime. He stated it was confusing, and the, "scheduled," dose was the only way the pharmacist could think of to make sure accuchecks were done every two hours, in addition to, before meals, and at bedtime (as required according to the orders). According to the DOP, the EMR had no way to change the information that was being put in for insulin dosing. He stated every entry under concentration and dose must be assigned a value, so they could not enter, "sliding scale," or anything			

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	similar for the dose, they had to pick a value. He stated the value they picked was the concentration available for the staff to give 100 units/ml (a potentially fatal dose), so that is why it showed that way in the "dose" area for Patient 1. During a Quality Department interview on August 13, 2015, at 10 a.m., the Chief Nursing Officer (CNO) stated when he spoke to RN 2 about double-checking the insulin dose, RN 2 told him she did not check it correctly. According to the CNO, RN 2 was aware that 100 units of insulin was, "way too much," and she would have stopped RN 1 if she knew that was how much she was getting ready to administer. The facility policy entitled, "Medication Administration," revised date March 2014, was reviewed on July 23, 2015. The following was indicated: "2. Accountability: Physician, Registered Nurses, Licensed Vocational Nurses, Respiratory Therapy, Pharmacy, Radiology 4. Purpose: To ensure safe administration of medications to patients. 5. Policy: 5.1 Medications are administered only after there is a written physician's order. 6. Observe the "Six Rights" when administering medications: 6.1.1 Right Patient			

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	6.1.2 Right Time 6.1.3 Right Medication 6.1.4 Right Dose 6.1.5 Right Route 6.1.6 Right Documentation 6.3 Reconciliation of MAR (Medication Administration Record) 6.3.1 The licensed Nurse will check the MAR against the physician's order 6.6 High Alert Medication such as Heparin, Insulin, Coumadin, PCA Infusions, and Vasoactive medications will be checked by two (2) licensed nurses prior to giving. A review of the resume and application for RN 1 was completed on July 23, 2015. The documents indicated RN 1 was issued a nursing license in 2010, but RN 1 did not begin working immediately as a nurse. She returned to school and received a bachelor's degree in 2014. According to the documents, her position at the facility was her first experience with responsibility for her own patients in an acute care setting (starting February 2015). A review of the facility's Nursing Orientation Agenda indicated training for Medication Safety/Medication Reconciliation (verification)/Glycemic (blood sugar) control topics were combined. The Agenda indicated a total time of 15 minutes was allotted for training during facility nursing orientation. . The employee file for RN 1 was reviewed on July 23, 2015. The file did not contain evidence of			

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	competency verification for MAR use, insulin administration, or knowledge of medications/dosages/calculations. During an interview with the Senior Human Resources Generalist (SHRG) on July 23, 2015, at 10 a.m., the SHRG stated there was no medication test in place to determine a baseline understanding and knowledge of the medication administration process. She stated the facility began to administer a pre-employment test in April of 2015, so RN 1, "just missed it." The facility failed to provide the safe administration of medication for a patient (Patient 1) which resulted in an adverse which the patient received 100 units of insulin for a blood sugar of 124 (normal) which caused life threatening hypoglycemia (low blood sugar), a transfer to the Intensive Care Unit (ICU) on a ventilator (breathing machine), and had the potential to result in the patient's death. 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

December 11, 2017

California Department of Public Health
Licensing and Certification Program
Riverside District Office
ATTN: Ella S.-Giauffer, HFEN Supervisor
625 East Carnegie Drive, Suite 280
San Bernardino, CA 92408

RE: Facility ID: **250000044**
Penalty Number: **250013623**
Complaint Intake Number: **CA00451429, CA00451880**

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

ID Prefix Tag: E 485
T22 DIV5 CH1 ART3-70263(g)(2) Pharmaceutical Service General Requirements

1. Insulin and Medication Error Reduction Strategies
   a. The Insulin Sliding Scale drug description was modified from Insulin 1 unit/0.01 ml description to Insulin "without concentration" and dose field modified from 1 unit to "1 dose". **(August 12, 2015)**
   b. Standard Order Sets default to PRN frequency. **(August 12, 2015)**
   c. The Insulin Sliding Scale format for standard Insulin Sliding Scale order sets changed from linear description to vertical description to improve Medication Administration Record Insulin Sliding Scale order clarity on the document. **(August 12, 2015)**
   d. The Pharmacy staff was notified and educated of the changes in Pharmacy Order Sets for Insulin Sliding Scale format. **(August 13, 2015)**
   e. The Director of Pharmacy will conduct monthly review of all Insulin Sliding Scale Orders for compliance to "PRN" status and revised format and will be monitored until three consecutive months yield 100% compliance. The data and analysis will be presented monthly to Quality Council for review and forwarded to the Governing Body for comment.

ID Prefix Tag: E 276
T22 DIV5 CH1 ART3-70214(a)(2)(A) Nursing Staff Development

1. Nursing Education
   a. The licensed nursing staff was provided education to the changes in the Medication Administration Record (MAR) via memorandum from Pharmacy regarding dosing and format for the Insulin Sliding Scale. **(August 13, 2015)**
   b. Medication Safety, Glycemic Control, and High Alert Medications incorporated to the Annual Clinical Skills Competency and New Nursing Orientation curriculum. **(September 21, 2015)**

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c. Medication Competency Examination Test administered to all clinical licensed nursing staff with passing grade of 100% or higher prior to the interview process for employment. **(September 21, 2015)**
d. Monitoring and Responsible Person(s): Random observations of Insulin preparation and administration process conducted by Nursing Directors and Managers in accordance with the hospital Policy and Procedure titled "High Alert Drugs". On the spot corrections are made when identified prior to the administration of the medication. Medication administration observations are discussed in the unit five minute meetings. **(September 23, 2015)**

ID Prefix Tag: E 297
T22 DIV5 CH1 ART3-70217(a) Nursing Service Staff

1. Nursing Staff
   a. The licensed nursing staff was provided education to the changes in the Medication Administration Record (MAR) via memorandum from Pharmacy regarding dosing and format for the Insulin Sliding Scale. **(August 13, 2015)**
   b. Medication Safety, Glycemic Control, and High Alert Medications incorporated to the Annual Clinical Skills Competency and New Nursing Orientation curriculum. **(September 21, 2015)**
   c. Medication Competency Examination Test administered to all clinical licensed nursing staff with passing grade of 100% or higher prior to the interview process for employment. **(September 21, 2015)**
   d. Monitoring and Responsible Person(s): Random observations of Insulin preparation and administration process conducted by Nursing Directors and Managers in accordance with the hospital Policy and Procedure titled "High Alert Drugs". On the spot corrections are made when identified prior to the administration of the medication. Medication administration observations are discussed in the unit five minute meetings. **(September 23, 2015)**
2. Insulin and Medication Error Reduction Strategies
   a. The Insulin Sliding Scale drug description was modified from Insulin 1 unit/0.01 ml description to Insulin "without concentration" and dose field modified from 1 unit to "1 dose". **(August 12, 2015)**
   b. Standard Order Sets default to PRN frequency. **(August 12, 2015)**
   c. The Insulin Sliding Scale format for standard Insulin Sliding Scale order sets changed from linear description to vertical description to improve Medication Administration Record Insulin Sliding Scale order clarity on the document. **(August 12, 2015)**
   d. The Pharmacy staff was notified and educated of the changes in Pharmacy Order Sets for Insulin Sliding Scale format.
   e. The Director of Pharmacy will conduct monthly review of all Insulin Sliding Scale Orders for compliance to "PRN" status and revised format and will be monitored until three consecutive months yield 100% compliance. The data and analysis will be presented monthly to Quality Council for review and forwarded to the Governing Body for comment.

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