California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA070000133	A. BUILDING _____ B. WING _____	C 06/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIONAL MEDICAL CENTER OF SAN JOSE	225 N JACKSON AVENUE SAN JOSE, CA 95116

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E 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of a complaint conducted from 4/11/17 through 4/12/17. For Complaint CA00529817 regarding State Monitoring, Adverse Events or series of adverse events, a State deficiency was identified, (See California Code of Regulations, Title 22, Section 70263(g)(2)). This was a State Immediate Jeopardy Administrative Penalty (AP IJ) Level 4. Inspection was limited to the complaint investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: 27194, Pharmaceutical Consultant II.	E 000	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH JUN 28 2017 L & C DIVISION SAN JOSE Tag E 485	
E 485	T22 DIV5 CH1 ART3-70263(g)(2) Pharmaceutical Service General Requirements (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	E 485	A1. The corrective action taken to correct the hospital's failure to administer two immediate (STAT) medications per policy are the following: 1. Policy# MED0306 Medication Administration was reviewed and determined to be compliant with CMS guidance, in terms of time expectations to deliver immediate STAT medications. Further, it was determined that the policy was inconsistently followed by staff (nurses and pharmacists).	

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Gore — TITLE: CQO — (X6) DATE: 6/27/17

Approved
7/7/17

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E 485	Continued From page 1 order. The prescriber or furnisher shall countersign the order within 48 hours. (2) Medications and treatments shall be administered as ordered. This Statute is not met as evidenced by: Based on interview and document review, the hospital failed to administer medications as ordered when Patient 1's two immediate (STAT) medications ordered (heparin, an anticoagulation therapy to prevent blood clot and valporic sodium, medication to prevent additional seizure) were delayed for administration by hospital staff for approximately 4 hours and 1.5 hours. These failures to administer the two critical medications timely contributed to a rapid decline in Patient 1's health status and may have resulted in significant physical impairment. Findings: A review of Patient 1's medical record on 4/11/17 indicated he was a 52 year old male patient brought in by ambulance with a cervical collar (neck brace, a medical device used to support a person's neck) to the hospital's emergency department (ED) on 3/22/17 at 7:03 a.m. after sustaining a fall at home. According to Patient 1's physical examination record documented on 3/22/17, the patient arrived at the emergency room awake, alert, and oriented with no motor or sensory deficits. Review of Patient 1's past medical record showed	E 485	Continued from page 1 – Tag E 485 Revisions to this policy were made under Procedure B, 2, b, "Medications ordered as "STAT" "NOW" shall be administered to the patient within 30 minutes of the order entry *and prior to transfer to receiving unit."* *(Changes to this section are the italicized portions.)* The policy changes were made and approved at the following committees: • Neuroscience Quality Review Committee (QRC) — 6/14/17 • Pharmacy and Therapeutics (P&T) Committee — 6/14/17 • Medical Executive Committee (MEC) — 6/26/17 • Board of Trustees (BOT) — 6/27/17 2. An education module was developed entitled Medication Administration by the Director of Education. — 6/14/17 a. Included in the module is the Medication Administration policy with the approved revisions. Educational materials and content were reviewed and approved by the Chief Nursing Officer (CNO). — 6/14/17 b. Education commenced on 6/14/17. — 7/7/17 c. All nurses will complete the Health Stream module by 7/7/17.	

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E 485	Continued From page 2 he had a history of left frontal meningioma (tumors that develop in the cells of the membrane that surrounds the brain and spinal cord) and the tumor was surgically removed at a hospital in 2003. About 2 months after the surgery, he had generalized seizures and he was placed on Dilantin (medication to control seizure) for about 5 years. He had no further seizures and after follow-up, the Dilantin was discontinued about 3 or 4 years ago. Further review of Patient 1's medical record dated 3/22/17 revealed, shortly after his arrival to the ED, he was taken to the radiology department for his initial computed tomography (CT) scan (a series of X-ray images taken from different angles and uses computer processing to create cross-sectional images, or slices, of the bones, blood vessels and soft tissues inside one's body) of the head and cervical spine to determine the extent of the injury and to determine if surgery was needed. At 7:50 a.m., the CT scan findings were communicated to Physician 1. The results showed evidence of a cervical vertebrae C7 (spinal segment located towards the bottom of the cervical spine which helps provide the neck with structural support) fracture. During a telephone interview with Physician 1 on 4/14/17 at 11:31 a.m., he stated the close proximity of the main artery to the fractured area of the neck was one of his concerns and he ordered a CT angiogram or CTA (a CT imaging test that looks at the arteries and tissues in various parts of the body) with contrast to study the nearby blood vessels to determine if there was any injury done to the artery. Review of the CT angiogram results on the diagnostic imaging report dated 3/22/17 at 9:45	E 485	Continued from page 2 – Tag E 485 Validation of education is the successful completion of a post-test. Remediation will be provided to those nurses who are unsuccessful with passing the post-test. Monitoring of completion rates of this education is occurring daily and reported to the CNO. d. Those nurses that are away on Medical Leave will not be allowed to return to work until the successful completion of the educational module and post-test. 3. Additional education has been provided to all nursing staff at Regional Medical Center of San Jose (RMCSJ) by the CNO, in a letter dated 6/15/17, related to Medication Administration, Handoff Communication and Neurological Assessment. a. Informal education has been provided at change of shift huddles to all working nurses regarding medication administration of STAT orders and the significance of handoff communication and neurological assessments.	6/15/17 6/8/17

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E 485	Continued From page 3 a.m. revealed evidence of left vertebral artery dissection in addition, to C7 fracture. During a telephone interview with Physician 1 on 4/14/17 at 11:31 a.m., he confirmed he requested a neurosurgery consultation to determine the next course of treatment after Patient 1's CTA diagnostic imaging results. A review of the neurosurgery consultation report dated 3/22/17 at 12:02 p.m. by Physician 2 indicated "Neurologically, Patient 1 has no focal deficit. His fracture is generally considered stable. I will keep him in a cervical collar for now; however, I am more concerned about his vertebral artery injury. If this truly has a clot, he may need to be anticoagulated. I recommend we get IR involved. ____ needs to have better imaging study like an MRI scan of his head just to make sure there is no sort of contusions or injury to his brain that would preclude him from having anticoagulation therapy..." A continued review of Patient 1's diagnostic imaging reports included the magnetic resonance imaging or MRI (a non-invasive imaging technology that produces three dimensional detailed anatomical images without the use of damaging radiation) of his head taken on 3/22/17 and it was documented at 1:25 p.m. the results revealed this patient has "no acute infarcts or hemorrhage." On 4/11/17 at 1:30 p.m. an interview with Physician Assistant 1 (PA1) was conducted. PA1 stated she was working in the interventional radiology department of the hospital on 3/22/17. Patient 1 was referred to her for follow-up care and treatment. A MRI diagnostic imaging study of Patient 1's head was ordered to determine	E 485	Continued from page 3 – Tag E485 4. Developed a daily auditing report to identify STAT medications administered > 30 minutes. This data is analyzed daily by the Chief Quality Officer (CQO) and CNO, to identify barriers that created a delay. Immediate process improvements are implemented, as delays are identified. Immediate coaching is provided to staff involved. B1. The title or positon of the person who will monitor the corrective action and the frequency of monitoring: 1. Responsibility for compliance to the administration of immediate (STAT) medications per policy will be the CNO and the Chief Medical Officer (CMO). A2. The corrective action taken to prevent medication order entry errors are the following: 1. The Cardiovascular Accident (CVA) Heparin protocol was reviewed and revised. There was clarity made to the section containing the Heparin bolus dosage order. This section now has a "hard stop" not present at the time of this event. This will allow the prescriber to bypass the dosage and thus complete the order.	6/14/17

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E 485	Continued From page 4 suitability for initiation of anticoagulation therapy. Upon release of the MRI findings at 1:25 p.m. and the "clean MRI" results, PA1 stated this was the confirmation that she needed to proceed with heparin anticoagulation protocol. The PA1 further stated she went into the hospital's Meditech (electronic health record system) system and ordered both the heparin bolus (a single dose of drug given all at once) dose and the heparin infusion or drip to be immediately administered. According to Patient 1's medical record, both the heparin bolus and heparin drip orders were entered at approximately 1:53 p.m. on 3/22/17. However, neither of the heparin orders were administered by nursing staff to Patient 1 until approximately 6:00 p.m. or 4 hours after the medications were ordered. When the PA1 was asked when she would expect the medication to be administered to Patient 1 on 4/11/17 starting at 1:30 p.m., she said "this is a STAT order; the medication should be given right away." She further stated that she even went to the inpatient pharmacy and informed one of the pharmacists about her new heparin orders. In an interview with the pharmacy manager (Pharm 1) on 4/12/17 at 3:30 p.m., she stated the verification of these two heparin orders was assigned to a clinical pharmacist (Pharm 2) on the 2 East floor. According to pharmacy record and Pharm 1, the Pharm 2 acknowledged the receipt of the heparin orders in about a minute after they were entered into the system. However, Pharm 1 stated the original heparin bolus order was put into the Meditech system with no dosage entered, and thus Pharm 2 was unable to complete the verification process until	E 485	Continued from page 4 – Tag E485 Further, an evidence based guideline recommended dose now appears in this section off to the side of the dosage. The provider, now, must free text in a dose for Heparin bolus or cannot proceed to the completion of this order. Revisions were made by Pharmacists in collaboration with the Medical Director of Neuroscience Department. The order set was reviewed and approved at the following committees: • Computer Physician Order Entry (CPOE) — 4/2017 • Neuroscience Operations Improvement Committee (OIC) — 5/24/17 • Pharmacy & Therapeutics Committee (P&T) — 4/12/17& 6/14/17 • Medical Executive Committee (MEC) — 6/26/17 • Board of Trustees (BOT) — 6/27/17 a. Education of the corrective actions was provided to all medical staff at RMCSJ, via the CMO Newsletter. — 6/26/17 2. Medical Staff Peer Review was completed on this case at May and June 2014 Neuroscience QRC with case review concluding on 6/14/17. — 6/14/17 a. It was determined that there were many system issues that ultimately led this negative patient outcome.	

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E 485	Continued From page 5 further clarification of the heparin order was confirmed with PA1. She further stated the process of contacting PA1 for clarification by Pharm 2 and some unforeseen technical issues with Meditech system took Pharm 2 longer than expected to verify this heparin bolus order. Review of the pharmacy record dated 3/22/17 indicated the heparin bolus order was not verified by Pharm 2 until 2:51 p.m., 58 minutes after the initial order entered by PA1. On 4/11/17 at 2:22 p.m., during an interview with the ED Nurse (RN1), he stated about 15 to 30 minutes prior to the end of his shift at 3:00 p.m., he had communicated with the intensive care unit (ICU) nurse (RN2) about transferring Patient 1 to ICU. However, he was told to hold Patient 1 in the ED until the patient was assessed by the trauma physician (Physician 3). He also stated he was aware of the pending heparin orders in the Meditech system, and as part of his hand off (a time when responsibility and accountability of care is transferred from one nurse to another at change of shift) process, had informed RN2 of the pending heparin orders. However, RN1 stated during the Patient 1's hand off to RN2, he was not aware that the two heparin orders had been verified by the pharmacy and were ready for immediate administration. On 4/11/17 at 3:20 p.m., during an interview with RN2, she stated Patient 1 arrived to the ICU at about 3:00 p.m. on 3/22/17, which was the time for the next shift change in the ICU. She said "I did not have much interaction with Patient 1" as she was preparing to do another hand off to her p.m. shift ICU nurse (RN3). On 4/12/17 at 2:20 p.m. during an interview with	E 485	Continued from page 5 – Tag E 485 Further, the therapy decisions of the Physician Assistant (PA) and her supervising physician who ordered the Heparin order were examined. It was determined that the Heparin order and treatment was appropriate, just not delivered timely. b. Education was provided by the Director of the Pharmacy and Medical Director of Neuroscience Department at the Neuroscience QRC meeting to the PA and fellow neuroscience physicians regarding the system changes made to prevent this event from occurring in the future. c. Education of the corrective actions made to order sets and policy revisions was provided to all medical staff at RMCSJ, via the CMO Newsletter. d. Further, this information will also be included in the P&T Newsletter.	6/14/17 6/26/17 6/28/17

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E 485	Continued From page 6 RN3, he recalled about 5 to 10 minutes after the start of his shift in the ICU, Patient 1 complained of feeling sick and then vomited in bed. RN3 said "it took about 15 to 20 minutes to clean up" as this patient was still in C-Spine precaution (patients with spinal precautions are turned very carefully to prevent flexion or movement of the vertebrae). RN3 stated a dose of Zofran (medication to prevent nausea and vomiting) was administered to Patient 1 to control his vomiting. Review of Patient 1's pharmacy record confirmed a dose of ondansetron (generic drug of Zofran) 4 mg was administered intravenously (IV) at 3:55 p.m. on 3/22/17. However, according to RN3, after administration of Zofran IV medication, Patient 1 experienced another episode of a seizure, and Physician 3 from the ED was brought in to the ICU for emergent treatment. According to the pharmacy record, two separate doses of lorazepam 2 mg IV were administered at 4:43 p.m. and 4:44 p.m. Review of the Patient 1's clinical notes dated 3/22/17 by Physician 4 indicated "called at 1630 for pt seizing, had recently vomited and maintained in C spine precautions. Seizure continuing and gave Ativan 2mg times 2 doses without resolution of seizure ...Anesth called and intubated at 1650 with glidescope and maintained in C collar. Physician 3 called and recommended Propofol and EEG" Continued review of the patient medication records indicated at 4:44 p.m. Physician 3 had ordered valproate sodium (medication to prevent seizure) 1500 mg IV STAT (to be given immediately). However, review of the record indicated the valproate sodium order was not verified by the pharmacy until 6:23 p.m., one and half hours after it was ordered by Physician 3.	E 485	Continued from page 6 – Tag E485 3. The second STAT medication error (Depakote) occurred when the provider entered the drug, dose and route of the medication on the order set but did not provide the par fill solution to mix the medication in. This required the pharmacist to clarify the order with the provider. A new order was generated by the pharmacist, which included the drug, dose, rout and par fill solution; however, the pharmacist failed to re-enter the order as a STAT medication. To prevent this from occurring in the future, revisions to the order set have been made. There is now a section included to assist the provider in the selection of a par fill solution along with the range of Depakote orders. Revisions to the order set were made by the Pharmacy Department in collaboration with the Medical Director of the Neuroscience Department. The order set was reviewed and approved at the following committees: • Computer Physician Order Entry (CPOE) 4/2017 • Neuroscience Operations Improvement Committee (OIC) 5/24/17	

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E 485	Continued From page 7 During an interview with Pharm 1 on 4/13/17 at 2:49 p.m., she stated the original valproate sodium order had a data entry error and the verifying pharmacist attempted to correct it by creating a new order of the same medication while discontinuing the old one. However, the pharmacist did not make the new valproate sodium order as an immediate order in Meditech. As the result, Pharm 1 confirmed the verification of the valproate sodium and printing of its label in pharmacy did not take place until approximately 6:23 p.m. on 3/22/17, and the subsequent IV administration of the medication to Patient 1 did not take place until 7:09 p.m. Review of the hospital policy dated 2/23/16 entitled, "Prescribing, Verification and Clarification of Medication Orders" on page 2 under "Prescribing and Verification of Medication Orders" it read "13. The medical staff approves turnaround times for processing medication orders. The turnaround times for this hospital are as follows: a. STAT medications: 15 minutes ..." During an interview with RN3 on 4/12/17 at 2:20 p.m., he stated he did not know there were heparin "STAT" orders written by PA1 earlier that afternoon on 3/22/17. He also stated he could not recall a hand off during the shift change or any discussion of the pending heparin STAT order between the RN2 and him on 3/22/17 at 3:00 p.m. He further stated he first learned of the heparin orders when he was in the patient's room while assisting Physician 3 with the EEG (electroencephalogram; a test that measures and records the electrical activity of your brain) procedure and Physician 3 asked him to start administering heparin to Patient 1 as soon as possible.	E 485	Continued from page 7 – Tag E485 • Pharmacy and Therapeutics (P&T) Committee • Medical Executive Committee (MEC) • Board of Trustees (BOT) a. Education of the corrective actions made to the order set was provided to all medical staff at RMCSJ, via the CMO Newsletter. b. Education concerning order set revisions was provided to all pharmacists by the Director of Pharmacy. B2. The title or positon of the person who will monitor the corrective action and the frequency of monitoring: 1. Responsibility for compliance to correct medication order entry will be the Director of Pharmacy and the CMO. A3. The corrective action to be taken to prevent the transfer of patients from one unit to another without administration of STAT medications:	4/12/17& 6/14/17 6/26/17 6/27/17 6/26/17 4/2017

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E 485	Continued From page 8 Further review of the Patient 1's medication administration record (MAR) indicated the heparin "STAT" order was not administered until approximately 6:00 p.m. Review of Patient 1's medical record did not find any hand off documentation between RN2 and RN3 during the p.m. shift change at 3:00 p.m. on 3/22/17. Review of the hospital document dated 4/2015 entitled, "Intensive Care Unit Standards of Care" on page 4 under "I. Assessment and Reassessment," it read "7. Change of shift hand-off will include on-coming and off-going RN doing a bedside double-check of patient status to include: review of all IV infusions/rates, assessment of skin, verification of relevant assessment findings (IE: neurological status, IABP settings, etc.) On 4/13/17 at 3:24 p.m. during an interview with Pharm 1, she confirmed the first dose of heparin orders written by PA1 was administered at approximately 6:00 p.m. on 3/22/17, 4 hours after they were ordered by PA1. Review of the hospital policy dated 6/28/16 entitled, "Medication Administration" on page 4 under procedure; it read "2. b. Medication ordered as "STAT" "NOW" shall be administered to the patient within 30 minutes of the order entry." On 3/23/17, additional MRI and neurological assessment of Patient 1 were conducted. Review of the MRI findings dated 3/23/17 revealed large pons (area of the brain that serves as a message station between several areas of the brain) infarct (a small localized area of dead tissue resulting from failure of blood supply) with extensive blockage of the left vertebral artery.	E 485	Continued from page 8 – Tag E 485 1. Policy# MED0306 Medication Administration was reviewed and determined to be compliant with CMS guidance, in terms of time expectations to deliver immediate STAT medications. Further, it was determined that the policy was inconsistently followed by staff (nurses and pharmacists). Revisions to this policy were made under Procedure B, 2, b, "Medications ordered as "STAT" "NOW" shall be administered to the patient within 30 minutes of the order entry *and prior to transfer to receiving unit." (Changes to this section are the italicized portions.)* The policy changes were made and approved at the following committees: • Neuroscience Quality Review Committee (QRC) 6/14/17 • Pharmacy and Therapeutics (P&T) Committee 6/14/17 • Medical Executive Committee (MEC) 6/26/17 • Board of Trustees (BOT) 6/27/17 2. An education module was developed entitled Medication Administration by the Director of Education. 6/14/17	

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E 485	Continued From page 9 Review of the neurological assessment dated 3/23/17 indicated "Neuro exam is very limited today, despite propofol (medication that results in a decreased level of consciousness) off since 8:15 a.m. Pt. opens eyes spontaneously, but does not track. Gaze in midline." And subsequent consultation dated 3/23/17 concluded the patient likely had Locked-in syndrome (a condition in which a patient is aware but cannot move or communicate verbally due to complete paralysis of nearly all voluntary muscles in the body except for vertical eye movements and blinking) with prognosis for functional recovery is poor.	E 485	Continued from page 9 – Tag E 485 a. Included in the module is the Medication Administration policy with the approved revisions. Educational materials and content were reviewed and approved by the Chief Nursing Officer (CNO). b. Education commenced on 6/14/17. c. All nurses will complete the Health Stream module by 7/7/17. Validation of education is the successful completion of a post-test. Remediation will be provided to those nurses who are unsuccessful with passing the post-test. Monitoring of completion rates of this education is occurring daily and reported to the CNO. d. Those nurses that are away on Medical Leave will not be allowed to return to work until the successful completion of the educational module and post-test.	6/14/17 6/14/17 7/7/17
A 014	1280.1(c) HSC Section 1280 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 014		

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A 014	1280.1(c) HSC Section 1280 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 014		

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A 014	1280.1(c) HSC Section 1280 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 014	1. Education was provided to all Pharmacists by the Director of Pharmacy, on the Provider Phone/Contact list, located in Meditech system. Pharmacist 2 was unaware that physician assistant's phone numbers are located I this repository. She instead thought it was a list for physicians only and spent a considerable amount of time attempting to locate the PA by telephoning the units she believed the PA to be at.	4/7/17

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A 014	1280.1(c) HSC Section 1280 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 014		

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A 014	1280.1(c) HSC Section 1280 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 014	B4. The title or position of the person who will monitor the corrective action and the frequency of monitoring: 1. Responsibility for compliance to the prevention of pharmacy delays related to difficulty in contacting providers will be the Director of Pharmacy. A5. The corrective action to be taken to improve handoff communication (both verbal and written) between nurses at change of shift/location are the following: 1. An education module titled Handoff Communication was developed by the Director of Education.	6/14/17

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A 014	1280.1(c) HSC Section 1280 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 014	b. All nurses will complete the Health Stream module. Validation of education is the successful completion of a post-test. Remediation will be provided to those nurses who are unsuccessful with passing the post-test. Monitoring of completion rates of this education is occurring daily and reported to the CNO. c. Those nurses that are away on Medical Leave will not be allowed to return to work until the successful completion of the educational module and post-test.	7/7/17

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			e. Direct observation audits will occur daily (M-F) to examine verbal handoff communication at shift change and patient transfers. Directors will be responsible for these audits.	9/30/17
A 014	1280.1(c) HSC Section 1280 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 014	2. Additional education has been provided to all nursing staff at Regional Medical Center of San Jose (RMCSJ) by the CNO, in a letter dated 6/15/17, related to Medication Administration, Handoff Communication and Neurological Assessment.	6/15/17
			a. Informal education has been provided at change of shift huddles to all working nurses regarding medication administration of STAT orders and the significance of handoff communication and neurological assessments.	6/8/17

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A 014	1280.1(c) HSC Section 1280 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 014		

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A 014	1280.1(c) HSC Section 1280 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 014		

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A 014	1280.1(c) HSC Section 1280 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 014		