	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPF AND PLAN OF CORRECTION IDENTIFICATION 050077			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2013			
	NAME OF PROVIDER OR SUPPLIER Scripps Mercy Hospital			STREET ADDRESS, CITY, STATE, ZIP CODE 4077 5th Ave, San Diego, CA 92103-2105 SAN DIEGO COUNTY					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPE	IOULD BE CROSS-	(X5) COMPLETE DATE		
	of Public Health during Complaint Intake Num CA00360799 - Substan Representing the Depa Surveyor ID # 22479, H The inspection was lime event investigated and findings of a full inspect Health and Safety purposes of this means a situation noncompliance with licensure has caused injury or death to the p The following reflects Department of Public of Entity Reported Inci Representing the Depa 1280.1 (a) Health and If a licensee of a subdivision (a), (b), of notice of deficience jeopardy to the healt required to submit department may	ber: Intiated artment of Public Health: HFEN does not represent the ction of the facility. Code Section 1280.1 section "immediate ja in which the lic one or more requirem , or is likely to cause, atient. s the findings of the 0 c Health during the inve dent : CA00360799	(c): For eopardy" censee's nents of serious California estigation		OCT 27				
Event ID:I	M5S711		10/9/2014	3:23	3:00PM				

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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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.

Chief Execution

(X6) DATE

10.27.14

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2013	
Personal Incorporation of the	ROVIDER OR SUPPLIER Mercy Hospital		SS, CITY, STATE, 2 San Diego, CA	ZIP CODE 92103-2105 SAN DIEGO CO	DUNTY	
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Event ID:	(c) For purposes jeopardy" means a noncompliance with licensure has cause injury or death to a pa (d)This section si occurring on or after to incidents occurrin the amount of assessed under such hundred thousand With respect to in January 1, 2009, th penalties assessed up to fifty thousand administrative penal dollars (\$75,000) administrative penal dollars (\$75,000) administrative penal thousand dollars (\$ subsequent violation issued after three issued immediate considered a first a the facility has no jeopardy violations to be in substantia federal licensing department shall ha factors when det administrative penalty 1279.1. (a) A hea subdivision (a), (b) report an adverse even	dollars (25,000) per violation. of this section "immediate situation in which the licensee's one or more requirements of ed, or is likely to cause serious atient. hall apply only to incidents r January 1, 2007. With respect ag on or after January 1, 2009, the administrative penalties odivision (a) shall be up to one dollars (\$100,000) per violation. Incidents occurring on or after he amount of the administrative under subdivision (a) shall be d dollars (\$50,000) for the first ty, up to seventy-five thousand for the second subsequent lty, and up to one hundred 100,000) for the third and every on. An administrative penalty years from the date of the last jeopardy violation shall be diministrative penalty so long as t received additional immediate and is found by the department I compliance with all state and laws and regulations. The ve full discretion to consider all ermining the amount of an y pursuant to this section. Ith facility licensed pursuant to 0, or (f) of Section 1250 shall ent to the department no later		3:00PM		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2013	
NAME OF PROVIDER OR SUPPLIER Scripps Mercy Hospital	STREET ADDRESS 4077 5th Ave, S		ZIP CODE A 92103-2105 SAN DIEGO COUNTY		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SHOL REFERENCED TO THE APPROPRIA	JLD BE CROSS-	(X5) COMPLETE DATE
detected, or, if that a emergent threat to the patients, personnel, of hours after the advee Disclosure of indi information shall be con- (b) For purposes of includes any of the follor (4) Care manager following: (A) A patient death with a medication en- to, an error involving dose, the wrong patier rate, the wrong prep- administration, exclud clinical judgment on dru A tag 001 The CDPH verified patient or the party re- adverse event by the time Title 22 Regulations 70263 (g) (2) Medica administered as ordere	 this section, "adverse event" owing: nent events, including the or serious disability associated rror, including, but not limited g the wrong drug, the wrong ent, the wrong time, the wrong route of ling reasonable differences in ug selection and dose. that the facility informed the esponsible for the patient of the me the report was made. tions and treatments shall be d. icies and procedures shall be 		 70263 (g) Medications and treatma administered as ordered. Medication Not Given – Medication Administration Policy <u>Responsible Person</u>: Chief Nurse Executive Immediately after the event the fowere taken: Leadership notification occurred of the investigation was initiated, statinterviewed and placed on admini Meetings on 7/2/13 at 8:00am, 11 2:00pm, and 5:00 pm, and on 7/3/11:00am and 3:30pm, and Root C on 7/3/13 at 1:00pm to assess gap policy/best interests of patient to eprocesses are put in place to previsk to future patients. <u>Education on Patient Advocacy</u> in Values and Therapeutic Interventi Professional Obligations process of 7/2/13. (Attachment 1: Education of Rosters) <u>Corrective Action</u>. The three empliin this event were placed on admini and appropriate corrective action a commenced. (Attachment 2: Admit Leave Letters) <u>SSRS Competencies</u>. All ED SSR oriented to the Pyxis profile procest beginning of shift. (Attachment 3: Competency Checklist) 	and Operations Illowing actions Illowing actions In 7/1/13 and ff were strative leave. :30 am, '13 at 8:30am, :ause Analysis os in practice vs ensure that ent immediate Critical Lab on and was initiated on Content and oyees involved histrative leave and education nistrative S nurses were ss upon	

AND PLAN OF CORRECTION IDENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2013	
and conservations and the	IAME OF PROVIDER OR SUPPLIER STREET ADDRE Scripps Mercy Hospital 4077 5th Ave			E, ZIP CODE CA 92103-2105 SAN DIEGO COUNTY		
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	consistency and incorporating the nu- treatment plan, implemented in coope The above regulation by: Based on interview, the hospital failed administered a medic threatening serum p found in the body th in the heart) level. of potassium in the b and death. Patient critically high serum cardiac arrest and of failed to implement procedures to includ "Critical Results Administration." In a update and comm regarding Patient 1's s Findings: On 6/30/13, Patient via the Emergency I of acute urinary trai	multiple hospital policies and de, "Chain of Command" and Reporting", and "Medication addition, nursing staff failed to nunicate pertinent information		Subsequent to the event the following were taken: <u>Emergency Department Action</u> : The involved ED RN was placed on Administrative Leave with subsequer action completed on 07/10/13. <u>Unit Education</u> : All <i>Emergency Depa</i> . nursing staff received Patient Advocat to include the expectation that if a men- not available timely, follow up commu- pharmacy occurs to ensure that their given as ordered. (Attachment 1: Edu Content and Rosters) This education initiated on 07/03/13 and continued e- until 100% completion. <u>Pyxis Orientation</u> : Site orientation for Systemwide Resource Services (SSF Emergency Department (ED) nurses includes specific orientation to the pro- medication feature unique to the Men- Emergency Departments; revision to Checklist was made. (Attachment 3: 4 and Competency Checklist) <u>Monitoring</u> : A random audit of a minir Emergency Department charts per m- conducted to confirm compliance with administration as ordered by the phys (Attachment 4: ED Nursing Audit) Compliance rates were reported mon- Quality Assurance and Performance Improvement Committee (QAPIC), wh trends were tracked and analyzed. Of process or performance improvement monitored and/or revised to ensure co- with stated action plan. Adjustments frequency and scope of audits were n- the direction of QAPIC.	nt corrective rtment acy training, edication is unication to nedication is ucation was each shift Scripps RS) now ofiled cy campus' the Orientation num of 70 onth was n medication sician. thly to the here data ngoing is were ompliance to the	07/23/13 07/29/13 08/26/13
Event ID:N		10/9/2014	4 2	:23:00PM		

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0. San San - S	Scripps Mercy Hospital 4077 5th /			E, ZIP CODE CA 92103-2105 SAN DIEGO COUNTY	07/30	JI 2013
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Event ID:	circulating blood) and Medical Doctor 1's Record. On 7/23/13 at 3: conducted with the assigned to care for 6/30/13 at about 7:3 1) received a call serum potassium potassium level range became aware of closer to 8:00 P.M. Kayexalate (a medic of potassium in the given to Patient physician's order fo expecting that the medication to the admitted to the h between 9:00 P.M. inpatient bed was 6/30/13, RN 1 transf the inpatient nursing never called the p release of the administered the Kaye A review of the h entitled "Medications Documentation," date the policy, "Media accordance with the licensed independent	ED Registered Nurse (RN) 1 Patient 1. RN 1 stated that on 30 P.M., the ED physician (MD informing him that Patient 1's level was 7.0. (A normal es between 2.7 and 5.5). RN 1 the elevated potassium level on 6/30/13 when MD 1 ordered cation used to treat high levels e blood) 30 Grams (gm) to be 1 orally. RN 1 scanned the r Kayexalate to the pharmacy pharmacy would deliver the ED. Patient 1 was being nospital and RN 1 found out and 9:30 P.M. that Patient 1's available. At 10:00 P.M. on ferred Patient 1 on a gurney to g unit. RN 1 stated that she harmacy to follow up on the Kayexalate. RN 1 never exalate to Patient 1 in the ED.		3 rd Floor Action: The involved 3 rd floor placed on Administrative Leave and si corrective action was completed betwe 07/12/13 and 08/02/13. <u>Unit Education</u> : All <i>3rd floor nursing</i> st Hospital B received Patient Advocacy include the expectation that the physic contacted if an ordered medication is to be administered to manage a critical v (Attachment 1: Education Content and This education was initiated on 07/03/ continued each shift until 100% compl <u>Housewide Education</u> : This training wa implemented for all nursing staff at bot campuses beginning 07/10/2013 and of until 100% completion is achieved. <u>Monitoring</u> : A minimum of 70 scenario- interview audits of nursing staffs' undo of the appropriate response to managi value result, to include contacting the the RN is unable to administer the med ordered. (Attachment 5: Scenario Base Interview Questions) Compliance rates were reported month Quality Assurance and Performance Improvement Committee (QAPIC), who trends were tracked and analyzed. On process or performance improvements monitored and/or revised to ensure com with stated action plan. Adjustments to frequency and scope of audits were ma the direction of QAPIC. 70213 (a) Written policies and procedu be developed, maintained and implement the nursing service.	ubsequent een aff at training, to cian is unable to alue result Rosters). 13 and etion. as then th ongoing -based onducted erstanding ing a critical physician if dication ed hly to the ere data going s were mpliance o the ade under	07/23/13 08/29/13 09/10/13

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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이 및 이 의 공가가 이 것	NAME OF PROVIDER OR SUPPLIER STREET ADD! Scripps Mercy Hospital 4077 5th Av			E, ZIP CODE CA 92103-2105 SAN DIEGO COUNTY	•	
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Event ID:	entitled "Medication was reviewed. Per- were to be scanned to An interview was co- of the ED (EDRNM) EDRNM stated that been available withir order was scanned to pharmacy never of physician's medication never called the pha- on the availability of further explained that the medication shou RN 1 within 1 hour of order. MD 1 wrote about 8:00 P.M. o transferred to the in P.M., two hours later. During the interview she faxed a repor inpatient nursing uni However, there was report that the administered. When nursing unit with Pa RN that the Kayexal to the patient in the E stated that she thoug the Kayexalate to t should have been more	nducted with the RN Manager on 7/25/13 at 8:45 P.M. The the Kayexalate should have twenty minutes of when the o the pharmacy. However, the received the scan of the n order for Patient 1. RN 1 armacy to follow up and check the Kayexalate. The EDRNM the ti was the expectation that d have been administered by of MD 1 writing the medication the order for the Kayexalate at		Responsible Person: Chief Nursing a Operations Executive MD Notification of Critical Test Resultest Report Policy Immediately after the event the follow were taken: Leadership notification occurred on 7 the investigation was initiated, staff vinterviewed and placed on administra Meetings on 7/2/13 at 8:00am, 11:30 2:00pm, and 5:00 pm, and on 7/3/13 11:00am and 3:30pm, and Root Cau on 7/3/13 at 1:00pm to assess gaps policy/best interests of patient to ens processes are put in place to prevent risk to future patients. Education on Patient Advocacy in Cr Values and Therapeutic Intervention Professional Obligations process was 7/2/13 and was ongoing at the Chula campus, Emergency Department and (Attachment 1: Education Content and Corrective Action. The three employed in this event were placed on administ (Attachment 2: Administrative Leave Education Expansion an audit of priotests cases and acute renal failure m was being conducted to assess the sissue and need for education. Subsequent to the event the following were taken: Utilizing a rapid cycle improvement m a task force was formed and met to d corrective action plan. Members inclumanagers, nurse directors, clinical infinurse specialist, clinical nurse specialist, clinical specialist, clinical specialist, clinical nurse specialist	Its – Critical ving actions 7/1/13 and vere ative leave. a m, at 8:30am, se Analysis in practice vs ure that t immediate itical Lab and s initiated on Vista d Rosters) ves involved rative leave. Letters) r critical lab anagement cope of the g actions vethodology, evelop ded nurse ormatics	07/31/13

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050077		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2013	
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RN 1 stated that a p until every physician RN 1 acknowledged th When Patient 1 arr unit, RN 1 gave a h of information about the nurse assigned informed RN 2 that administered to Patien A review of the Adm	batient should not leave the E n's order has been complete nat did not occur. ived on the inpatient nursi- nand-off report (verbal exchan- the patient's status) to RN to care for Patient 1. RN t the Kayexalate was new int 1 in the ED.	ED ed. ng ge 2, 1 ver 1,	lab. A pilot program was developed Result Report generated by the on demand every 6 hours on 4 Hospital A and 3 pilot units at H report would contain the previce of critical test results. The repor reviewed by the charge nurse. would reconcile all nursing acti any critical lab test result that of documentation that the physici notified of the critical test result who received the telephonic no critical test result by the lab an	d. The Critical Test e EMR would print pilot units at lospital B. The bus 24 hours' worth ort would be The charge nurse ions and address did not have an had been t with the nurse otification of the d/or any physician	08/05/13	
for "Kayexalate 30 (10:00 P.M.)" On 7/23/13 at 10 conducted with RN that Patient 1 was a P.M. RN 2 stated the inpatient nursing began the admission 2 tried to contact I (MD 2) by calling his nursing station. MD MD 2 a voice mail	gm po (orally) @ 2200 h 30 A.M., an interview w 2, of the inpatient nursing u admitted to on 6/30/13 at 10:0 that when Patient 1 arrived g unit, within 15 minutes, s n process. At 10:59 P.M., F Patient 1's attending physici s number that was listed at t 2 never answered, so RN 21 I message informing MD 2	rs. vas nit 20 on he RN an he left 2 of	inquire if the notification to the completed. The nurse is requir actions that were taken and ap document. Note: The nurse m clinical judgment and determin physician does not need to be critical test result. That clinical documented. The charge nurse is placed in a 3 ring binder, sig and any unreconciled finding w so that the nurse supervisor/m aware of any staff nurse needii counseling. See standard work developed for the charge nurse	physician was ed to identify the propriately hay use their e that the notified of the judgment must be e reviewed report ned and dated, vould be red circled anager would be ng coaching or c instructions e. (Attachment 7:	08/06/13	
asked MD 2 to call I never made any further RN 2 explained that having a serum po 11:30 P.M. when she	her back. RN 2 stated that s er attempts to call MD 2. she found out about Patient otassium level of 7.0 at abo e reviewed the paper work th	he 1 out	from the Clinical Lab Informatic identifies the critical lab test re- previous 3 hours. See sample 8: Sample Critical Test Report work instructions that were dev	on System that sults for the report (Attachment ED) See standard veloped for the	08/06/13	
	(EACH DEFICIENCY REGULATORY OR medication order ar RN 1 stated that a p until every physician RN 1 acknowledged th When Patient 1 arr unit, RN 1 gave a h of information about the nurse assigned informed RN 2 tha administered to Patien A review of the Adm revealed that there of for "Kayexalate 30 (10:00 P.M.)" On 7/23/13 at 10 conducted with RN that Patient 1 was a P.M. RN 2 stated the inpatient nursing began the admission 2 tried to contact 1 (MD 2) by calling hi nursing station. MD MD 2 a voice mai Patient 1's admissio asked MD 2 to call 1 never made any further RN 2 explained that having a serum po 11:30 P.M. when sho	DEF CORRECTION IDENTIFICATION NUMBER: 050077 ROVIDER OR SUPPLIER Mercy Hospital STREET ADD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) medication order and then calling the pharmad RN 1 stated that a patient should not leave the E until every physician's order has been complete RN 1 acknowledged that did not occur. When Patient 1 arrived on the inpatient nursi unit, RN 1 gave a hand-off report (verbal exchan of information about the patient's status) to RN the nurse assigned to care for Patient 1. RN informed RN 2 that the Kayexalate was new administered to Patient 1 in the ED. A review of the Admission Orders, written by MD revealed that there was a second physician's ord for "Kayexalate 30 gm po (orally) @ 2200 h (10:00 P.M.)" On 7/23/13 at 10:30 A.M., an interview w conducted with RN 2, of the inpatient nursing u that Patient 1 was admitted to on 6/30/13 at 10:0 P.M. RN 2 stated that when Patient 1 arrived the inpatient nursing unit, within 15 minutes, s began the admission process. At 10:59 P.M., f 2 tried to contact Patient 1's attending physici (MD 2) by calling his number that was listed at t nursing station. MD 2 never answered, so RN 2 MD 2 a voice mail message informing MD 2 Patient 1's admission to the nursing unit. RN asked MD 2 to call her back. RN 2 stated that s never made any further attempts to call MD 2. RN 2 explained that she found out about Patient having a serum potassium level of 7.0 at about	OF CORRECTION IDENTIFICATION NUMBER: A BUILDI 050077 STREET ADDRESS, CITY, STATE Mercy Hospital STREET ADDRESS, CITY, STATE Mercy Hospital STREET ADDRESS, CITY, STATE Mercy Hospital SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID medication order and then calling the pharmacy. (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID 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 nurusing unit. RN 2	PF CORRECTION IDENTIFICATION NUMBER: A BUILDING 050077 IN A BUILDING ROWDER OR SUPPLIER STREET ADDRESS. CITY. STATE. ZIP CODE Mercy Hospital STREET ADDRESS. CITY. STATE. ZIP CODE BULDING STREET ADDRESS. CITY. STATE. ZIP CODE Mercy Hospital STREET ADDRESS. CITY. STATE. ZIP CODE BULDING STREET ADDRESS. CITY. STATE. ZIP CODE BULDING BULDING SUMMARY STATEMENT OF DEFICIENCIES ID ILECK PREV REGULATORY OR LSC IDENTIFYING INFORMATION) PREV Mercy physician's order has been completed. N1 stated that a patient should not leave the ED Until every physician's order has been completed. A pilot program was developed. 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 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)." The charge nurse contacts the inquire if the notification the previous doment to sample Critical Test Report 1 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 The charge nurse contacts the inquire if the notification tha mas bepond 32 DP.M.	GORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLET 950077 STREET ADDRESS, CITY, STATE, ZIP CODE 07/2 Rerey Hospital STREET ADDRESS, CITY, STATE, ZIP CODE 07/2 Image: Construction of the state of the construction of the constru	

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETE DATE	
	"Admitted for UTI (potassium) = 7 Rena potassium level of potassium and neede attending physician. called MD 2 once sh a critical value p informing MD 2 of level she said she c patient. Per RN 2, at 11 attempted to admin dose of Kayexalate restless and not coo dose of Kayexalate, Admission Orders, w stated that she info did not administer informed the attendin never informed the at instruct RN 2 to do so. On 7/1/13, at midnig to inform her that Patient 1's potassiun value). RN 2 stated RN to find out if M had not. Neither the second call to MD 2. The hospital's por "Critical Results Re	Patient 1's serum potassium those to continue monitoring the 1:40 P.M. on 6/30/13, RN 2 nister the 10:00 P.M. ordered to Patient 1. Patient 1 was operative; therefore, the second written by MD 1 in Patient 1's vas never administered. RN 2 rmed the Charge RN that she the Kayexalate but she never ng physician. The Charge RN attending physician nor did she		(Attachment 9: Critical Test Work Instructions) The task force met and the an additional 3 units at Hosy timeframe of the report was hours. An executive committee me Chief Executive, the Clinical Quality Director, the Chief of Pathology Medical Directors Result policy was amended of repeat critical test results critical language would be u personnel when notifying a presult and the Lab would alw of a critical test result (MD c well). (Attachment 10: Revis Policy) The policy was officia Medical Executive Committee Task force met and reviewed The Emergency Department was changed to review the p began to be sent via email to nurse. The decision was ma to an additional 2 units at Ho Task force met and determin successful and all remaining Hospitals went live effective Formal education on the revi process for critical test result distributed to all Registered I Learning Management Syste <u>Monitoring</u> : A minimum of 70 results were evaluated monti attached audit tool. (Attachm Results Audit)	pilot was extended to bital A and the shortened to 12 eting including the Lab Director, the f Staff and the . The Critical Test so that the definition was made clearer, sed by laboratory hurse of a critical test vays notify the nurse ould be notified as ed Critical Result ally approved by the te. d preliminary data. critical test result or evicus 4 hours and o each ED charge de to extend the pilot was units at both August 21, 2013. ised quality control reporting was Nurses via the em. D critical test lab hly using the	08/21/13 08/20/13 08/20/13 08/21/13	

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The policy defined values/interpretations is in imminent of morbidity, or serious evaluated immediatel value/finding of a test During the interview A.M., RN 2 stated multiple attempts to critical value serum RN 2 acknowledge advocated for the pa Supervisor regarding level and to inform MD 2 had not respond Further review of the entitled "Critical Res 2012, indicated	a "critical result" as "Those that indicate that the patient danger of death, significant adverse consequences unless y. Critical results may be the that was ordered routinely." with RN 2, on 7/23/13 at 10:30 that she should have made call MD 2 regarding Patient 1's potassium level. In addition, d that she should have atient by calling the Operations Patient 1's critical potassium the Operations Supervisor that led to her call.		Quality Assurance and Perfor Improvement Committee (Quality Assurance and Perfor Improvement Committee (Quality of the committee of the commit	APIC), where data alyzed. Ongoing rovements were ensure compliance ustments to the its were made under edures that require patient care, ocess and the I be developed and with medical staff. Aursing and the following actions ication occurred on was initiated, staff I on administrative t 8:00am, 11:30 am, n 7/3/13 at 8:30am, icot Cause Analysis as gaps in practice vs	
2. If phone report			processes are put in place to risk to future patients. Education on Patient Advoca	prevent immediate	
 Notify appropri- critical result and de and time in the n responsible caregive physician at a minim 	ocument physician name, date, nedical record. The licensed r will attempt to contact the um of 15 minute intervals up to		Professional Obligations prov 7/2/13 and was ongoing at the campus, Emergency Departre (Attachment 1: Education Con- <u>Corrective Action</u> . The three	cess was initiated on the Chula Vista ment and 3rd floors. Intent and Rosters) employees involved	
	(EACH DEFICIENCY REGULATORY OR greater than 6.0 is The policy defined values/interpretations is in imminent of morbidity, or serious evaluated immediatel value/finding of a test During the interview A.M., RN 2 stated multiple attempts to critical value serum RN 2 acknowledged advocated for the po Supervisor regarding level and to inform MD 2 had not respond Further review of the entitled "Critical Res 2012, indicated reported to the Li (RN): 1. Write down critical 2. If phone report reported result. 3. Notify approprint critical result and du and time in the m responsible caregive physician at a minim	DF CORRECTION IDENTIFICATION NUMBER: 050077 STREET ADDRESS Aercy Hospital STREET ADDRESS Recy Hospital STREET ADDRESS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 "ResponsibilitiesResults 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,	OF CORRECTION IDENTIFICATION NUMBER: A BUILDI 050077 STREET ADDRESS, CITY, STATE Mercy Hospital SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 "ResponsibilitiesResults 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 approp	PF CORRECTION IDENTIFICATION NUMBER A BUILDING 050077 B WING 30VIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE Aercy Hospital STREET ADDRESS, CITY, STATE, ZIP CODE Image: Complexity of the compl	PF CORRECTION DENTFICATION NUMBER A BUILDING COMPLETE 050077 A BUILDING A BUILDING COMPLETE Rery Hospital STREET ADDRESS, CITY, STATE, ZIP CODE 07/30 ROUDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 07/30 REFUNCTION NUMMER STREET ADDRESS, CITY, STATE, ZIP CODE 0 SUMMANY STATEMENT OF DEFICIENCIES D PROVIDER'S PLAN OF CORRECTION IECONDERCY MUST BE PRECEDED BY FULL PREFIX FLAN OF CORRECTION REFERENCED TO THE APPROMENTE DEFICIENCIES D PROVIDER'S PLAN OF CORRECTION greater than 6.0 is considered 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 result may be the valuefinding of a test that was ordered routinely." Compliance rates were reported monthly to the Quality Assurance improvement Sourace and Performance improvement Sourace and P

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		050077	B. WING		07/3	0/2013
	ROVIDER OR SUPPLIER Mercy Hospital	STREET ADDRESS, 4077 5th Ave, Sa		E, ZIP CODE CA 92103-2105 SAN DIEGO COUNTY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD) REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETE DATE
	 command for critical charge nurse, manage An interview was co and Operations Exect 11:15 A.M. The CN regarding the nurses values was to contal MD did not respond of command up to the patient's critical lab explained that the representative. Patient's critical lab explained that the representative is consistent to a separate the appropriate set in the set of the the explained that "In the member has experise the appropriateness of patient care and the issue directly with following steps will Staff member Manager/Supervisor of weekends, call the Op The Manager 	e RN was the patient's ent 1 was vulnerable and had a n level. RN 2 should have nt 1 to get medication orders ther potassium level. However, ospital's policy and procedure Command", dated July 2013, he event a patient care staff enced a clinical issue involving of a physician's management are not successful in resolving with the physician(s) of record, I be followed: to inform the Charger Nurse, of the unit, or if after hours or		Leave. (Attachment 2: Administrative Letters) Chain of Command Policy Subsequent to the event the following were taken: The involved RN was placed on inve- leave. Subsequent corrective action of completed between 07/12/13 and 08. All 3rd floor nursing staff at Hospital I Patient Advocacy training, to include expectation that the chain of comman- if a physician does not return phone of (Attachment 1: Education Content and This education was initiated on 07/03 continued each shift until 100% comp Patient Advocacy training was then in for all nursing staff at both campuses 07/10/13 and ongoing until 100% corr achieved. <u>Monitoring</u> : A minimum of 70 scenar interview audits of nursing staff were monthly to validate nursing staffs' uno of the chain of command process. (A Scenario Based Interview Questions) Compliance rates were reported mon Quality Assurance and Performance Improvement Committee (QAPIC), w trends were tracked and analyzed. O process or performance improvemen monitored and/or revised to ensure c with stated action plan. Adjustments frequency and scope of audits were r the direction of QAPIC.	g actions stigatory was /02/13. B received the nd is initiated calls id Rosters) 8/13 and bletion. mplemented beginning mpletion was io-based conducted derstanding ttachment 5:) thly to the here data ngoing ts were ompliance to the	07/01/13 07/23/13 08/29/13

PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS- COMPLE		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP AND PLAN OF CORRECTION IDENTIFICATION 050077			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2013	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLE DATE 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). Director >				STREET ADDRESS, CITY, STATE, ZIP CODE				
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).	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEEDED BY	FULL	PREFIX	IX (EACH CORRECTIVE ACTION SHOULD BE CRO		(X5) COMPLETE DATE
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 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		Manager/Supervise Manager/Superviser the medical chain of nursing chain of or Assistant Administr Operating Executive) Chain of Comm Management Patient Issue > Cal Operations Supervi unresolved or if M Department In the event the Si Chief of the Departu the Physician Lead or Senior Director contacted. The Op a current list of individuals." On 7/1/13 at 6:56 A RN 2 that Patient During the interview A.M., she explaine she received a cal (A technician who Patient 1's heart rh RN 2 that Patient 1' long pauses in between the paine of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of	sor and physia is responsible for for of command (see belo ommand (Manager a rator > CNOE (Cl), and Flow Chart II Physician > Notify sor > Contact Ph 1D is unavailable, co upervisor is unable for ment, the Chief of S ership Cabinet (Hosp of Medical Affairs berations Supervisor contact information A.M. the lab called a 1's serum potassiu with RN 2, on 7/23 d that at 7:00 A.M. I from the Telemetry of was continuously bythm). The technic 's heart rate was in ween each beat. R	cian, the billowing both low) and the > Director > hief Nursing - Medical Manager or ysician. If all Chief of to reach the taff, Chair of pital B only) should be will maintain for these and informed m was 7.6. /13 at 10:30 on 7/1/13, y Technician monitoring ian informed the 40's with N 2 went to				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI			(X3) DATE SURVEY COMPLETED	
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a far a f	ROVIDER OR SUPPLIER Mercy Hospital	STREET ADDRESS 4077 5th Ave, Sa		IP CODE 92103-2105 SAN DIEGO CC	DUNTY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE ACTIOI REFERENCED TO THE APPR	N SHOULD BE CROSS-	(X5) COMPLETE DATE	
	went down to the 30 is 60 to 100 beats per for the Rapid Resport patients that are of quickly called a Co- personnel work to re because the patient The Code Blue was pronounced dead on 7 A review of Patier 7/9/13, listed the foll time of Patient 1's dea 1. Cardiac Ar Hyperkalemia 2. Acute Renal Failure 3. Urosepsis (an infe urinary tract infection) 4. Diabetes Mellitus 5. Possible UGI (upper The facility's n requirements, jointl combination, has ca serious injury or deal constitutes an imm	7/1/13 at 7:30 A.M. Int 1's Autopsy Report, dated lowing clinical diagnoses at the th: rest Secondary to Severe					
Event ID:	M5S711	10/9/2014	3.2	3:00PM			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050077		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2013	
NAME OF PROVIDER OR SUPPLIER Scripps Mercy Hospital			STREET ADDRESS, CITY, STATE, ZIP CODE 4077 5th Ave, San Diego, CA 92103-2105 SAN DIEGO COUNTY				
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