Reviewed By:

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF PUBLIC HEALTH acility Notified (X1) PROVIDER/SUPPLIER/CLIA Name: (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: Date: AND PLAN OF CORRECTION COMPLETED Time: 050057 Notified By 12/24/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE Kaweah Delta Medical Center 400 W. MINERAL KING, VISALIA, CA 93291 TULARE COUNTY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES Ю PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE This Plan of Correction constitutes Kaweah The following reflects the findings of the Department Delta Medical Center's (KDMC) written of Public Health during an inspection visit: allegation of compliance for the deficiencies cited. The statements made on this plan of correction are not an admission and do not Complaint Intake Number: constitute agreement with the alleged CA00253068 - Substantiated deficiencies herein. Specifically, Kaweah Delta Medical Center (KDMC) disputes the facts contained in the notice of deficiency, including Representing the Department of Public Health: but not limited to, statements attributed to Surveyor ID # 27709, HFEN RN 3,MD2 and the Chief of Obstetrics (MD 9). KDMC has taken actions to prevent reoccurrence, including: The inspection was limited to the specific facility Immediate Action and Systemic Changes: event investigated and does not represent the Pursuant to KDMC's Quality Assurance/
Performance Improvement (PI) program and in findings of a full inspection of the facility. compliance with AP.87 "Sentinel Event and 12/20/10 Adverse Event Response and Reporting" Health and Safety Code Section 1280.1(c): For policy, a "Case Review Committee" (CRC) was convened on 12/20/10. Members of the CRC purposes of this section "immediate jeopardy" means a situation in which included the Chief of Staff, CMO, CNO, COO, Director of Maternal-Child Health, OB Nurse noncompliance with one or more requirements of Manager, Director of PI, and Director of Risk licensure has caused, or is likely to cause, serious Management. The CEO notified the President injury or death to the patient. of the Board of Directors by 12/20/10. 2) A thorough and credible Root Cause 12/21/10 Analysis (RCA) was conducted. Meeting dates were 12/21/10, 1/6/11 and 2/11/11. MD 1, MD Health and Safety Code 1279.1(b)(4)(C) 1/6/11 (b) For purposes of this section, "adverse event" 2, MD 9 (Chief of Obstetrics), CEO, CNO, CMO, Medical Director for Anesthesia, Director includes any of the following: 2/11/11 of Maternal-Child Health, L&D Nurse Manager Care management (4) events. including the Clinical Educators, Registered Nurses, the following: Director of Pl and the Director of Risk (C) Maternal death or serious disability associated Management participated in the RCA process. with labor or delivery in a low-risk pregnancy while The event was reported to the California Department of Public (CDPH) as an "adverse event" pursuant to H&S Code 1279.1 on 12/22/10 being cared for in a facility, including events that occur within 42 days post delivery and excluding 12/22/10. deaths from pulmonary or amniotic fluid embolism, The RCA findings and plan of correction were acute fatty liver of pregnancy or cardiomyopathy. reported to the Board of Directors on 1/17/11. 1/17/11

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

CONSTITUTES

on 3/22/11.

10:20:09AM

The findings of the RCA were presented to Medical Care Review Committee (MCRC) on

TITLE

3/2/11 and the Patient Safety Committee (PSC)

(X6) DATE

3/2/11

3/22/11

Any deficiency statement ending with an asteriak (*) 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 continue the facility. participation.

IMMEDIATE

7/21/2011

DEPO OF HEALTH OFFICE LICENSING & CERTIFICATION .

State-2567

Event ID:E81511

DEFICIENCY

JEOPARDY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		(X3) DATE SUR COMPLETE	
		050057	B. WING	<u> </u>	12/24	V2010
NAME OF PR	OVIDER OR SUPPLIER	STREET ADDRESS	S. CITY, STAT	re, ziP CODE		
Kaweah D	elta Medical Center	400 W. MINERA	IL KING, V	ISALIA, CA 93291 TULARE COUNTY		
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<u> </u>	Continued From page	1 T 3. 70203(a)(2) Developing,		Members of the MCRC include, the designee of all clinical departments	, the Peer	
		elementing written policies and		Review Committee (PRC) chair an		
[ultation with other appropriate		Director of PI. Other MCRC attended		
}	health professional	• • •		the CEO, CMO, COO, Director of F		
	shall be approved	by the governing body.		determined by the chair. MCRC p		ı
		approved by the administration		Quality Council on 3/23/11. The ca		3/23/11
	and medical staff when	• • • • • •		1 was presented to the Medical Ex	ecutive	
		nterview, clinical record and		Committee (MEC) on 3/2/11.	dia a) -4-66	3/2/11 12/29/10
		ent review, the facility failed to large		 The matter was referred for med peer review for both MD 1 and 2. 		12/29/10
	followed Medical	· ·		provided by MD 1 and 2 was peer	- 1	
l	1	ns, and the Rapid Response		12/29/10 and 1/10/11, respectively		1/10/11
		cedure requiring physicians to		i. Persons Responsible: Chief of S		
	,	e and to request consultation		Review Committee (PRC) and ME oversight and ensuring proper adherenced to the committee (PRC) and ME oversight and ensuring proper adherenced to the committee (PRC) and ME oversight and ensuring proper adherenced to the committee (PRC) and ME oversight and ensuring proper adherenced to the committee (PRC) and ME oversight and ensuring proper adherenced to the committee (PRC) and ME oversight and ensuring proper adherenced to the committee (PRC) and ME oversight and ensuring proper adherenced to the committee (PRC) and ME oversight and ensuring proper adherenced to the committee (PRC) and ME oversight and ensuring proper adherenced to the committee (PRC) and ME oversight and ensuring proper adherenced to the committee (PRC) and ME oversight and ensuring proper adherenced to the committee (PRC) and the committee		
	'	sultant (senior staff obstetrician)		Medical Staff bylaws, rules & regulation		
		occurred when MD 1 and MD		ii. Monitoring process: Results an		
	· ·	assistance when Patient 1's 1500 cc's (measure of volume)		peer review are confidential, privile	- 1	
		a normal vaginal delivery. The		protected pursuant to California Ev	idence Code	
		am (RRT) was called and not		1157. 4) Consistent with KDMC's commit	ment to	
	1 -	Patient 1. These failures in		patient safety and quality care, on		1/3/11
	combination delayed	l life saving measures to		Post-Partum Hemorrhage (PPH) H		
	Patient 1 and led to her	rdeath.		immediately reviewed and revised.	,	
				education of nursing staff was com L&D Clinical Nurse Educator via 1:		
	Findings: On 12/27/11 Patient	the diplost record		in-service meetings on unit and L&	, ,	
		: 1's clinical record was dindicated Patient 1 arrived at l		meeting on 1/13/11. Immediate ed	ucation of	1/13/11
		/10 at 2:10 a.m., to deliver a		OB physicians was completed at O		4.0.4
		outine vaginal delivery. Patient		meeting on 1/3/11. Changes included it. If the patient continues to bleed a		1/3/11
•	1	acute distress with по knowл		equals 750 cc or more for a vagina		,
	health risks and was	at a full term pregnancy with		1500cc or more for a C-Section, the	1	
	ruptured membranes.	}		be transferred to the Main OR for fo		
	Th			intervention/evaluation and possible	e surgical	
!	The medical recor	rd indicated Patient 1 had por in a normal manner in a		intervention.		
	highesser mional lan			<u> </u>		
Event ID:	E81511	7/21/2011	10::	20:09AM		
ABORATOR	Y DIMECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE		(X8) DATE

- 111LE

8/15/11

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING			
	_	050057		B. WING		12/24	2010
NAME OF PR	OVIDER OR SUPPLIER	Sı	REET ADDRESS,	CITY, STATE,	ZIP CODE	·	
Kaweah D	elta Medical Center		0 W. MINERAL	KING, VIS	ALIA, CA 93291 TULARE COUNTY		
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	documentation on the Flowsheet dated membrane (bag of flow artificial (broken instrument) method. 3:18 p.m. and follow placenta, Patient fliters) blood loss and hour time frame (According to the Opat 9:22 p.m., MD1 aby repair of the cervand curettage and the (a tube with a ball temporary reduction bleeding). The atternusuccessful. LD Flowsheet indicate the labor and deliver because of the continued to the con	livery room. According Labor and Deliver 10 at 11:26 a. uid in the uterus) was open with a sterile After delivery of the owing the expelling sustained a 1500c continued to bleed or from 3:18 p.m. to observative Report dated attempted to stop the local laceration, fraction are placement of a Bak oon used vaginally to on used vaginally to on of postpartum mpts to stop the bleed of the patient was may room to the Operational of the Intraoperative on. RN 8 requested on the Intraoperative of the Intraoperative of the OR for the Intraoperative of the Intraoperative of the OR for the Intraoperative of the OR. MD esponded to the call	ory (L D) m., the s ruptured e pointed baby at of the c (1 1/2 ver a one 4:20 p.m.). 12/17/10 bleeding al dilation or provide uterine ding were oved from ing Room 4:20 p.m. r the next re Record a "senior R. RN 9 nior Staff 8 (Senior	•	If blood loss exceeds 750cc for vagor 1500cc for a C-Section before patransferred to OR but bleeding has patient is stable, the physician may no further intervention is necessary ii. If Main OR does not have a room if the patient is too unstable to wait to the Main OR, the patient will be to the OBOR and the Rapid Respo and Main OR Team will be called to support the patient and the L&D stail. Persons Responsible: L&D Nurand Director of Maternal Child Hear ensuring L&D staff are competent i understanding & complying with poprocedures and monitoring is compercedures and monitoring is compercedures and ensuring proper adhed Medical Staff bylaws, rules & regularity. Monitoring process: Pursuant to California Maternal Quality Care Co (CMQCC –described below) "OB H Toolkit", a "de-brief" is promptly cor 100% of all OB hemorrhages using "Team de-briefing form", which incliprimary nurse and the primary physical described below to be provided to the proportunities for improvement. In addition, 100 % of PPH occurrent monitored monthly by the PI depart Results will be reported to MCRC a	atient can be stopped and determine of available or for transfer transferred in the case of the case o	
	period Patient 1 ha constant trickle) fo Intraoperative Reco (10 at 5:25 p.m MD 2(Anesthesiologist	d been bleeding (b r1hour and 41 minu	oright red lates. The las dated I 9 asked r the		Committee for a minimum of 4 mon compliance with the revised policy. 5) On 1/6/11, the implementation o Communication "White Board" in cases implemented pursuant to the Communication and Communication (Communication	f a ases of PPH California	1/6/11
Event ID:	E81511	<u>. </u>	7/21/2011	10:20	:09AM		
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	Continued From page	3	This is a dry erase board the rooms on the L&D unit when	-
	was needed. MD 2 in 10, according p.m. the RRT came in inside the OR by MI tube in Patient 1 an RRT to enter the Comeasures (Code Blu for 72 minutes. On 12/28/10 at 12:30 3 confirmed she was entire active labor an updated MD 1 as to confirmed giving MD 1500 cc's. RN 3 confirmed giving MD 1500 cc's. RN 3 confirmed labor and excessive bleeding at 4 interview, MD 1 confrom the normal delivicould not see when coming from. When have called for assisted RRT, MD 1 did not On 5/4/11 at 3:10 p.m. confirmed knowledge bleeding at the time OR. MD 2 confirmed	e) were begun and continued p.m., during an interview, R as with Patient 1 during the delivery. RN 3 confirmed shall patient 1's condition. RN 1 an estimated blood loss of firmed Patient 1 was moved lelivery area to the OR due (4:20 p.m. on 11.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1	These boards are cleaned uses in accordance with Information of the policies and procedures. A physicians and nursing staff purpose and use of the white presented by L&D Nurse M. The white board was review nursing staff and physicians CME on 2/16/11. III. This is a checklist utilize staff to improve communicate care providers during a PP A. Administration of Oxyge B. Vital Signs with O2 saturation of C. Start 2nd IV D. Insert Foley catheter E. Keep patient warm F. Evaluate blood loss even bleed G. Medications: Methergine Misoprostol H. Consider Bakri Balloon I. Draw Labs J. Emergency Release Blood (PRBC 2 units) K. Fresh Frozen Plasma (if units PRBC) iv. Persons Responsible: and Director of Maternal Chees and Director of Maternal Chees are less than the staff are communicated in the control of the province of the complying L&D staff are communicated in the communicated in	between patient fection Prevention on in-service to ff regarding the lite board was lanager on 1/6/11. Inved with L&D s at the mandatory I d by L&D nursing ation between health H, including: Interpretation every 5 min I s min during active I service of Products I giving more than 2 L&D Nurse Manager I spetent in in with policies &
	amount of urine out given. When asked	nd/or blood loss, vital sign: put and the amount of fluid what she would have don ted, in retrospect, she shoul nce.	PRC, Chief of Staff and Ch oversight and ensuring pro	ief of Obstetrics for per adherence to
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING			
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	Chief of Obstetrics a (MD 9) confirmed I Patient 1's case. MD the events leading u	m., during an interview, the and Vice Chair of Medical Staff knowledge and familiarity with 9 confirmed that she reviewed up to Patient 1's death. When		v. Monitoring process: 100 % of PPH occurrences are m monthly by the Maternal Child He KDMC PI department. Results w to MCRC and PSC Committee for 4 months to assure compliance w practice. 6) On 1/6/11, Policy AS.16 Rapid	alth and vill be reported r a minimum of ith the new Response	
	stated that MD 1 showhen excessive bleedi The facilities policy	and procedure of the "Medical		Team (RRT) was reviewed by RC led to the addition of an Intensivis in Labor & Delivery and OB/GYN Rooms effective immediately. Immediately of nursing staff was cortain.	t to the RRT Operating nediate npleted by	January
	date of 5/10/10." was section titled, "General	ulations with a board approval s reviewed on 12/27/10. The ral Conduct of Care, Revised: ter number "14. Consultation is		Manager via 1:1 stand-up in-servi on both units as well as, an L&D I staff meeting on 1/13/11. OB, And	ce meetings Nurse esthesia &	2011
	Staff is required in the diagnosis is obscup procedures have be complicated situations practitioners may be which the attending consultant shall offindings and recease16. The attending temporarial for responsible	ne Consulting or Active Medical he following situations: athe after ordinary diagnostic pen completedc. in unusual where specific skills of other neededf. complex cases for needs additional advise. 15. make and sign a record commendationsin every such anding practitioner is primarily equesting consultation when g in a qualified consultant. and Procedure from the reviewed on 3/15/11 titled, ions" last approved by the dicated, "Intra-anesthetic Care:		Intensivist Physicians educated to policy on 1/6/11. i. Persons Responsible: L&D Nu & Director of Maternal Child Healt L&D staff are competent in underscomplying with policies & procedumonitoring is completed. MEC, P Staff and Chief of Obstetrics for o ensuring proper adherence to Mebylaws, rules & regulations. Direct Emergency and Critical Care Sen Medical Director for ensuring RRT completed. ii. Monitoring process: 100% of Roccurrences are monitored by the committee (appropriate use of, prooutcomes and clinical outcomes), KDMC PI Department. Results a MCRC and Patient Safety Commit	rse Manager th for ensuring standing & ires and RC, Chief of versight and dical Staff ctor of vices and RRT monitoring is RT RRT ocess and the re reported to	1/6/11
	AFollowing are sa met 3. Proper and	fety guidelines that need to be adequate use of monitoring od pressuretemperature		minimum of 4 months to assure of Consistent with the PI plan RRTs throughout KDHCD, are monitored	ompliance. in L&D, and	
Event ID:	E81511	7/21/2011	10:20	D:09AM		
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(A) ID PRETIX TAG SUMMAY STATEMENT OF DEPCIENCIES (EACH DEPCIENCY MUST BE PRECEDED BY FULL REQUATORY OR ISCIDENTEY WAS INFORMATION) Continued From pags 5 probe) 5. Accurate and careful monitoring of vital signs, medications and main events during anesthesia on the hospitals anesthesia record. 6. Accurate charting and monitoring of fluids, blood transfusions including but not limited to gains or losses On 5/14/11 the facility policy and procedure titled, 'Repid Response Team' dated and approved 12/13/10, was reviewed. The policy and procedure indicated, 'Policy' Rapid Response Team' dated and approved Cardiact. Life Support Standard Procedures benone is for evaluation of questionable medical conditionsfunctions under authority of Intensive Care Medical Director in Oalaboration with Primary Care Physicianor Alternate physician Dio cument at ion:IV. D. The RRT/Intensivis/managing physician/RN shall collaborate on course of treatment with the utimate goal to be expedited access to care and transport to the proper level of careVIRRT will document assessment interventions on the Rapid Response Team FormInclude reason called, vital signs, symptoms and response to interventions." On 12/31/10 during review of patient 1's clinical record, Final autopsy report indicated the following: "I. Massive blood loss A. Immediate post-partum (after delivery of a baby) uterus with 3 cm lacerationlower uterine segment. B. Hemorrhagic centix and let parametrium (skin issue of the lower vagina and the ligaments). II. After resuscitation: A sternate feature. B. Excortation of the skin over the sternum EVENT (DESTITUTE) Continued From page 5 In APP To Content the Apple Response at the medical conditions. A left throacotomy interventions." Divide the proper level of care It is clinical record, Final autopsy report indicated the following: "I. Massive blood loss A. Immediate post-partum (after delivery of a baby) uterus with 3 cm laceration	<u></u> _		050057	B. WING		12/24	/2010
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Continued From page 5 probe) 5. Accurate and careful monitoring of vital signs, medications and main events during anesthesia on the hospitals anesathesia record. 6. Accurate charting and monitoring of fluids, blood transfusions including but not limited to gains or losses On 5/14/11 the facility policy and procedure titled, "Rapid Response Team" dated and approved 12/13/10, was reviewed. The policy and procedure midicated, "Policy Rapid Response Team (RRT) using standard assessment process with Advanced Cardiac Life Support Standard Procedurepurpose is for evaluation of questionable medical conditionsfunctions under authority of Intensive Care Medical Directorin collaboration with Primary Care Physician Or o u m en t a t i o n : IV. D. The RRT/Intensivis/trumanaging physician/RN shall collaborate on course of treatment with the utilimate goal to be expedited access to care and transport to the proper level of careVIRRT will document assessment interventions on the Rapid Response Team Formindude reason called, vital signs, symptoms and response to interventions." On 12/31/10 during review of patient 1's clinical record, Final autopsy report indicated the following: "I. Massive blood loss A. Immediate post-perture (after delivery of a baby) uterus with 3 cm lacerationlower uterine segment. B. Hemorrhagic cervix and left parametrium (skin issue of the lower vagina and the ligaments). II. After resuscitation: A. left thoracotory inclsion, 17 cm. A. Sternal fracture. B. Excoriation of the skin over the sternum Event (DE81511 Textra (Deceivance of that is propertied by an RRT Nurse at the time of the RRT. The data entered into ICU Nurse Rangeer or designeer or designeer or essence of the review within the next turns at the time of the RRT. The data entered into ICU Nurse Rangeer or designeer or designee for review within the RRT and RRT comfilted to Circu Nurse Manager with every large and procedure in RRT. 2. If discrepancies exist, the ICU Nurse Manager will review with the R	Kawesh D	elta Medical Center	400 W. MINERA	L KING, VISA	LIA, CA 93291 TULARE COUNT	f	
Continued From page 5 probe) 5. Accurate and careful monitoring of vital signs, medications and main events during anesthesia on the hospitals anesathesia record. 6. Accurate charting and monitoring of fluids, blood transfusions including but not limited to gains or losses On 5/14/11 the facility policy and procedure titled, "Rapid Response Team" dated and approved 12/13/10, was reviewed. The policy and procedure midicated, "Policy Rapid Response Team (RRT) using standard assessment process with Advanced Cardiac Life Support Standard Procedurepurpose is for evaluation of questionable medical conditionsfunctions under authority of Intensive Care Medical Directorin collaboration with Primary Care Physician Or o u m en t a t i o n : IV. D. The RRT/Intensivis/trumanaging physician/RN shall collaborate on course of treatment with the utilimate goal to be expedited access to care and transport to the proper level of careVIRRT will document assessment interventions on the Rapid Response Team Formindude reason called, vital signs, symptoms and response to interventions." On 12/31/10 during review of patient 1's clinical record, Final autopsy report indicated the following: "I. Massive blood loss A. Immediate post-perture (after delivery of a baby) uterus with 3 cm lacerationlower uterine segment. B. Hemorrhagic cervix and left parametrium (skin issue of the lower vagina and the ligaments). II. After resuscitation: A. left thoracotory inclsion, 17 cm. A. Sternal fracture. B. Excoriation of the skin over the sternum Event (DE81511 Textra (Deceivance of that is propertied by an RRT Nurse at the time of the RRT. The data entered into ICU Nurse Rangeer or designeer or designeer or essence of the review within the next turns at the time of the RRT. The data entered into ICU Nurse Rangeer or designeer or designee for review within the RRT and RRT comfilted to Circu Nurse Manager with every large and procedure in RRT. 2. If discrepancies exist, the ICU Nurse Manager will review with the R							
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On 5/14/11 the facility policy and procedure titled, "Rapid Response Team" dated and approved 12/13/10, was reviewed. The policy and procedure indicated, "Policy: Rapid Response Team (RRT) using standard assessment process with Advanced Cardiac Life Support Standard Procedurepurpose is for evaluation of questionable medical conditionsfunctions under authority of Intensive Care Medical Directorin collaboration with Primary Care Physicianor Alternate physician Documentation of current interventions." IV. D. The RRT/intensivist/managing physician/RN shall collaborate on course of treatment with the ultimate goal to be expedited access to care and transport to the proper level of careVIRRT will document assessment interventions." On 12/31/10 during review of patient 1's clinical record, Final autopsy report indicated the following: "I. Massive blood loss A. Immediate post-perturn (after delivery of a baby) uterus with 3 cm lacerationlower uterine segment. B. Hemorrhagic cervix and left parametrium (skin tissue of the lower vagina and the ligaments). II. After resuscitation: A. left thoracotomy incision, 17 cm. A. Sternal fracture, B. Excoriation of the skin over the sternum 3) timely response of physicians 4) completion of the debrifing with staff involved in the RRT dedical fiel CU Nurse Manager will review with the RRT RN and the RRT Medical Director. 3. Aggregate data is presented at the RRT committee meetings monthly for analysis and actions as needed. 4. Beginning 9/1/11, findings and actions of the RRT committee meetings monthly for analysis and actions as needed. 4. Beginning 9/1/11, findings and actions of the RRT committee meetings wonthly for analysis and actions as preded. 5. Beginning 9/1/11, findings and actions of the RRT committee meetings wonthly for analysis and actions as preded. 6. Opportunities for improvement relative to nursing practice will be managed individually by the respective nursing manager with appropriate education and progressive discipline if indi		signs, medications anesthesia on the h Accurate charting ar transfusions including	and main events during nospitals anesthesia record. 6. and monitoring of fluids, blood		at the time of the RRT. The da RRT database. All RRT forms ICU Nurse Manager or design within the next business day a 1) completeness of form 2) ap Standardized Procedures base	ata entered into are submitted to be for review and evaluated for: propriate use of ed on	
symptoms and response to interventions." On 12/31/10 during review of patient 1's clinical record, Final autopsy report indicated the following: "I. Massive blood loss A. Immediate post-partum (after delivery of a baby) uterus with 3 cm lacerationlower uterine segment. B. Hemorrhagic cervix and left parametrium (skin tissue of the lower vagina and the ligaments). II. After resuscitation: A. left thoracotomy incision, 17 cm. A. Sternal fracture. B. Excoriation of the skin over the sternum 6. Opportunities for improvement relative to nursing practice will be managed individually by the respective nursing manager with appropriate education and progressive discipline if indicated. 7) On 1/10/11, all Anesthesia providers attended a Mandatory Morbidity and Mortality Review meeting where care of Patient 1 was reviewed, including review of Mass Transfusion Protocol and RRT processes in L&D.	 -	"Rapid Response T 12/13/10, was review indicated, "Policy: Fusing standard asset Cardiac Life Support is for evaluation conditionsfunctions Care Medical Dir Primary Care Physip Documentation RRT/Intensivist/manacollaborate on course goal to be expedited to the proper level of	eam" dated and approved yed. The policy and procedure rapid Response Team (RRT) as sment process with Advanced a Standard Procedurepurpose of questionable medical under authority of Intensive rectorin collaboration with iclanor Alternate physician in:IV. D. The aging physician/RN shall to of treatment with the ultimate access to care and transport frameVIRRT will document		3) timely response of physiciar of the debriefing with staff involved. If discrepancies exist, the IC Manager will review with the RRT Medical Director. 3. Aggregate data is presented committee meetings monthly fractions as needed. 4. Beginning 9/1/11, RRTs that identified opportunities for implemented at the RRT committemeetings to be analyzed for refor implemented corrective act 5. Beginning 9/1/11, findings a RRT committee will be reported MCRC. RRT cases will be refiphysician and/or nursing peer	ns 4) completion lived in the RRT. U Nurse RT RN and the I at the RRT or analysis and the may have rovernent will be see monthly commended and ions. Indications of the dimonthly to erred to	9/1/11
		symptoms and response On 12/31/10 during record, Final autopsy "I. Massive blood k (after delivery of lacerationlower uter cervix and left paramy vagina and the ligam left thoracotomy in	review of patient 1's clinical report indicated the following: oss A. Immediate post-partum a baby) uterus with 3 cm rine segment. B. Hemorrhagic etrium (skin tissue of the lower lents). II. After resuscitation: A. ncision, 17 cm. A. Sternal		6. Opportunities for improvemenursing practice will be managed by the respective nursing manapropriate education and prodiscipline if indicated. 7) On 1/10/11, all Anesthesia pattended a Mandatory Morbidi Review meeting where care of reviewed, including review of Mandatory Morbiding review of Mandatory M	ed individually ager with gressive providers ty and Mortality Patient 1 was Mass Transfusion	1/10/11
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							(XA) DATE

8/15/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPT OF HEALTH THE HOLD FASSING & DERTY FILATION - FASSING

-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM 050057		(X2) MULT A. BUILDII B. WING	TIPLE CONSTRUCTION		E SURVEY PLETED
							12/24/2010
NAME OF PI	ROVIDER OR SUPPLIER	j	STREET ADDRESS,	CITY, STATE	, ZIP CODE		
Kaweah I	Delta Medical Center	· .	100 W. MINERAL	KING, VIS	ALIA, CA 93291 TULARE CO	DUNTY	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 1 MUST BE PRECEEDED BY F LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE ACTIVE)	ON SHOULD BE CROSS-	
IAG	REGULATORY OR	Lac IDENTIFTING INFORMAT	iON)	IAG	REFERENCED TO THE APP	ROPRIATE DEFICIENCY	DATE
	Continued From page	6			i. Persons Responsible:	MEC, PRC, Chief	fof
	C. Hemorrhagic perio	cardiac fluid Clinica	summary:		Staff and Medical Director		i
	previous medical				oversight and ensuring p		0
		•	eMassive		Medical Staff bylaws, rule	es & regulations.	
	1	•	,		ii. Monitoring process:		
	blood component tr				100 % of PPH occurrence	•	
			platelet		monthly by the Maternal		1
	transfusionInternal		nearly a		KDMC Pi department. F	Results will be repo	orted
	complete lack of blood	with incisions"	J		to MCRC and PSC Comr		
					of 4 months to assure co	mpliance with poli-	cies
	In summary MD 1	and MD 2 failed	to request		and procedures.		
	assistance as requir	red by Medical Sta	aff Bylaws		8) On 1/10/11, KDMC's a	administration and	1/10/11
		es and Regulations			clinical department of OB	3/GYN jointly agree	ed to
	policies and procedu	-			participate in the Californ	ia Maternal Qualit	у
	condition declined as				Care Collaborative (CMC	QCC), which aims t	to
		- : :	Palae Diood		improve readiness, recog	gnition, response,	and
	loss which ultimately le	ead to her death.			reporting of OB hemorrha		I
	1				policies and procedures		
	The facility's failure is		1		organized, practiced prot	•	\
	or is likely to cause,	, serious injury or de	eath to the		multi-disciplinary training		mely
	patient, and therefo	ore constitutes an	immediate		response. The primary a		
	jeopardy within the	meaning of Health	and safety		is to improve California h		
	Code section 1280.1.	-	• }		resources for responding		
			Ì		increasing the use of pro		1
	This facility failed to	prevent the deficier	vv(ies) as		improving availability of a	-	dard
	described above that				and state-of-the-art medi-		
	•				replacement options.	J, g	
	serious injury or deat	•	1		i. Persons Responsible:	L&D Nurse Mana	ger
	constitutes an imm	• • •	I .		& Director of Maternal Ch		- 1
	meaning of Health	and Safety Code	e Section		L&D staff are competent		9
	1280.1(c).		}		complying with policies &		
					monitoring is completed.	•	ef of
	1		1		Staff and Chief of Obstet		
	}		}		ensuring proper adheren		1
		•			bylaws, rules & regulation		}
	1		1		ii. Monitoring process: La		r
	-		\ \		submits to the Director of		
			ĺ		PPH cases for review.	· · · · · · · · · · · · · · · · · · ·	
			}				Į.
	<u> </u>						
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ABORATO	RY DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESEN	TATIVE'S SIGNAT	URE	TITLE		(X8) DATE
>	Finde	K. Mm	···		CEC)	8/15/11
Any derive	ncy statement ending with an ex		——————————————————————————————————————	dion may be	excused from correcting providing	no it is determined	V1. 3 1 11
•	• • •		•	-	r excused from correcting providil ngs above are disclosable 90 day	_	
	- '	•	-		plans of correction are disclosable	T	
•	=	-			n of correction is requisite to corr		÷ / •
participation						У/Г 	
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DEP. OF HEALTH CERTICES LICENSING & DERTIFICATION - FRESHO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER;	<u> </u>	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING		
•	050057	B. WING		12/24	/2010
NAME OF PROVIDER OR SUPPLIER Kawesh Delta Medical Center	STREET ADDRES		ZP CODE BALIA, CA 93291 TULARE COUNTY		
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUR REFERENCED TO THE APPROPRIATE	D SE CROSS-	(X5) COMPLETE DATE
previous medical deliveryextensive blood component tr. 5 units of pl transfusionInternal complete lack of blood in summary MD 1 assistance as required Medical Staff Rule policies and procedu condition declined as loss which ultimately less that therefore is fixely to cause, patient, and therefore period within the Code section 1280.1. This facility falled to described above that serious injury or deat constitutes an immodel.	cardiac fluid. Clinical summary: history not available. Vaginal vaginal hemorrhage, Massive anafusions13 units of RBC's, as ma and 1 platelet examinationnearly awith incisions" and MD 2 failed to request ed by Medical Staff Bytaws, as and Regulations and RRT ares when Patient 1's medical a result of excessive blood		Five (5) specific PPH data elen submitted to CMQCC monthly Coordinator for Maternal-Child CMQCC data received will be a monthly to the Director of Maternal Health and the Chief of Obstet and in addition reviewed quarks Committee. Next OB Committee. Next OB Committee. Next OB Committee on 1/14/11, the L&D department the "Under Buttock Drape" procentains a graduated fluid colle KDMC's objective was to improquantitative measurement of "eblood loss" during immediate period. Stocking of this supply manufacturer and in-service to was completed 1/14/11. OB P Anesthesia providers were eduproduct at the 2/16/11 mandate "Obstetrical Emergencies". i. Persons Responsible: L&D Manager and Director of Mater Health for ensuring L&D staff a in understanding & complying to procedures and monitoring is complying to the complete of Staff and obstetrics for oversight and en adherence to Medical Staff bylaregulations.	by the PI Health. Submitted rnal-Child rics for review, erly by OB ree meeting is mendations, nt purchased duct which rction pouch. ove the team's estimated ost-partum from the nursing staff hysicians and rcated on the ory CME on Nurse nal Child re competent with policies & completed. Chief of suring proper	October 2011 1/14/11 1/14/11 2/16/11
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Any deficiency statement ending with an esterisk (*) 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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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING			
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEPICIENCIES MUST BE PRECEEDED BY SCIDENTIFYING INFORMAT	FULL	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLETE DATE
	transfusion(nternal complete lack of blood. in summary MD' 1 assistance as requir	cardiac fluid. Clinical history not available history not available vaginal hemorrhage ansfusions13 units as ma and examination with incisions" and MD 2 failed and by Medical Stand Regulations are when Patient a result of exceud to her death. a deficiency that it serious injury or constitutes and meaning of Health prevent the deficiency and the patient, and additional prevent the deficiency is likely to the patient, and additional property.	ole. Vaginal geMassive of R8C's, 1 plateletnearly a to request leff Bylaws, 3 and RRT 1's medical essive blood that caused, deeth to the immediate and safety ency(les) as y to cause, and therefore within the de Section		ii. Monitoring process: 100 % of PPH occurrences monthly by the Maternal Cl KDMC PI department. Re reported to MCRC and PSI minimum of 4 months to as with the new practice. 10) Pursuant to CMQCC's on 1/13/11, L&D Nursing st in-service on "OB Hemorrh Management of Stat OB", V RRT process and Chain of L&D Clinical Nurse Educat i. Course presented eviden current practice skills requi situations. ii. Course Objectives includ 1. Discuss clinical manifest hemorrhage 2. Verbalize triggers for eat 3. Verbalize triggers for eat 3. Verbalize the pathophys Disseminated Instravascula the post partum hemorrhag 4. Discuss management of hemorrhaging patient 5. Compete obstetric hemo drill iii. Persons Responsible: Manager and Director of M Health for ensuring L&D sta in understanding & comply procedures and monitoring MEC, PRC, Chief of Staff a Obstetrics for oversight and adherence to Medical Staff regulations.	nild Health and sults will be C Committee for a sure compliance recommendations aff attended age Care-Critical which included the Command by the or. ced-based and red for OB critical ded: attion of perinatal dry recognition in the patient the perinatal dry recognition in the perinatal dry recognitio	1/13/11
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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER	R:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING		* *-
	•	050057		B. WING		12/24/2010
	ovider on Supplier ofta Medical Center	<u>j</u>	REET ADDRESS, CIT W. MINERAL KI		93291 TULARE COUNTY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		TAG REF	PROVIDER'S PLAN OF CORRECT ICH CORRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DI	E CROSS COMPLETE
	previous medical deliveryextensive blood component to 5 units of pl transfusionInternal complete lack of blood. In summary MD 1 assistance as require Medical Staff Rule policies and procedu condition declined as loss which ultimately let The facility's faiture is or is likely to cause, patient, and therefor jeopardy within the Code section 1280.1. This facility failed to described above that serious injury or deat constitutes an immediate of the constitutes an immediate of the constitutes an immediate of the constitutes an immediate constitutes and constitutes an immediate constitutes and constitutes an immediate constitutes an immediate constitutes an i	rardiac fluid. Clinical shistory not available. vaginal hemorrhage ansfusions13 units of a sma and 1 p examinationne with incisions" and MD 2 falled to ad by Medical Staff s and Regulations alres when Patient 1's a result of excessive	VaginalMassive RBC's, latelet larly a request Bylaws, nd RRT medical re blood caused, h to the nmediate d safety r(ies) as cause, herefore nin the	100 % monthl KDMC reporter minimular with policy and Ar outside Center Californ on 2/10 i. Court Obstet Hemor Patient Partum Perspe ii. Court 1. Defit 2. List partum 3. Deschemon 4. Discoregardiii. Pers Manag Health in unde proced	se Titles included: "Manageric Emergencies: Post-Part rhage Use of Bakri Balloon is" and "Process Changes in Hemorrhage from Nursing	alth and vill be mittee for a ompliance ing Medical Physicians esented by sternal-Fetal ntral se Manager ement of sum in OB in Post cof o patient ssues urse I Child competent in policies & inpleted.
S			7/21/2011	Obstet adhere regulat	rics for oversight and ensu nce to Medical Staff bylaw	ring proper
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTAT	IVE'S SIGNATURE	TITLE	(X8) DATE
Munday K. Mann	<u> </u>	CEO	8-15-11
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that other sefeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclossible 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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PRETIX TAG Continued From page 5 C. Hemorrhagic pericardisc fluid. Clinical summary:previous medical history not available. Vaginal deliveryaxtensive vaginal hemorrhageMassive blood component transfusions13 units of RBC's, 5 units of plasma and 1 platefet transfusionsInternal examinationmeerly complete fack of bloodwith incisions In summary MD 1 and MD 2 failed to request assistance as required by Medical Staff Bylaws, Medical Staff Rules and Regulations and RRT policies and procedures when Patient 1's medical condition declined as a result of excessive blood loss which ultimately lead to her death. The facility's failure is a deficiency that has caused, or is likely to cause, serious injury or deeth to the patient, and therefore constitutes an immediate jopardy within the meaning of Health and Safety Code section 1280.1. This facility failed to prevent the deficiency(tee) as described above that caused, or is likely to cause, serious injury or deeth to the patient, and therefore constitutes an immediate jopardy within the meaning of Health and Safety Code Section 1280.1(c). Event ID-E61511 7/21/2011 10/20/98AM	Kaweah D						TULARE COUNTY		
C. Hemorrhagic pericardiac fluid. Clinical summany:previous medical history not available. Vaginal deliveryaxtensive vaginal hemorrhageMassive blood component transitusions13 units of RBC's, 5 units of plasma and 1 platelet transfusionInternal examinationnearly a complete lack of bloodwith incisions" In summary MD 1 and MD 2 felled to request assistance as required by Medical Staff Bylaws, Medical Staff Rules and Regulations and RRT policies and procedures when Patient 1's medical condition declined as a result of excessive blood loss which ultimately lead to her death. The facility's failure is a deficiency that has caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeoparty within the meaning of Health and Safety Code Section 1280.1(c). Event ID-E81511 7/21/2011 102-208AM	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY	FULL	PREFIX	(EACH CORT	RECTIVE ACTION SHOULD B	E CROSS-	COMPLETE
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Any deficiency statement ending with an esterisk (*) 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 discloseble 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 benimued program participation.

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MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 400 W. MINERAL KING, VISALIA, CA 93281 TULARE COUNTY		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER
STREET ADDRESS, CITY, STATE, ZIP CODE		050057
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 C. Hemorrhagic pericardiac fluid. Clinical summary:previous medical history not available. Vaginal deliveryextensive vaginal hemorrhageMassive blood component transfusions13 units of RBC's, 5 units of plasma and 1 platelet transfusion literal examination pearly a	STREET ADDRESS, CITY, STATE, ZIP CODE	
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c. Pernormagic pericardiac hiot. Clinical summary:previous medical history not available. Vaginal deliveryextensive vaginal hemorrhageMassive blood component transfusions13 units of RBC's, 5 units of plasma and 1 platelet transfusion linemal examination nearly a		Continued From page 6
complete lack of bloodwith Incisions" In summary MD 1 and MD 2 failed to request assistance as required by Medical Staff Bytaws, Medical Staff Rules and Regulations and RRT policies and procedures when Patient 1's medical condition declined as a result of excessive blood loss which ultimately lead to her death. The facility's failure is a deficiency that has caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and sefety Code section 1280.1. This facility failed to prevent the deficiency(les) 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 Sefety Code Section 1280.1(c).	bleeding and > 1500ml cumulative blood loss, re-Evaluate bleeding and vital signs. If cumulative blood loss > 1500ml, > 2 units or RBC's, or 1 platelet innearly a	C. Hemorrhagic pericardiac fluid. Clinical siprevious medical history not available. deliveryextensive vaginal hemorrhage blood component transfusions13 units of 5 units of plasma and 1 p transfusionInternal examinationnet complete lack of bloodwith incisions" in summary MD 1 and MD 2 failed to assistance as required by Medical Staff Medical Staff Rules and Regulations ar policles and procedures when Patient 1's condition declined as a result of excessive loss which ultimately lead to her death. The facility's failure is a deficiency that has or is likely to cause, serious injury or death patient, and therefore constitutes an impedance of Health and Code section 1280.1. This facility failed to prevent the deficiency described above that caused, or is likely to serious injury or death to the patient, and the constitutes an immediate jeopardy with meaning of Health and Safety Code
Event ID: E81511 7/21/2011 10:20:09AM LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		

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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 disclossable 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 discloseble 14 days following the data these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050057	A. BUILDI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
AME OF PROVIDER OR SUPPLIER Kawesh Delta Medical Center STREET ADDRESS, CTY, STATE, ZIP CODE 400 W. MINERAL KING, VISALIA, CA 93291 TULARE COUNTY						
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROV	SHOULD BE CROSS-	(X6) COMPLETE DATE	
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Event ID:E81511	7/21/2011):0 0 AM			

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BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X8) DATE 11 MAY WILLIAM CEO 8-15-		Medical Staff Rule policies and procedu condition declined as loss which ultimately let. The facility's failure is or is likely to cause, patient, and therefoliopardy within the Code section 1280.1. This facility failed to described above that serious injury or deat constitutes an immediating of Health	is and Regulations and RRT ires when Patient 1's medical is a result of excessive blood and to her death. Is a deficiency that has caused, serious injury or death to the ire constitutes an immediate meaning of Health and safety prevent the deficiency (ies) as caused, or is likely to cause, to the patient, and therefore iediate jeopardy within the		Committee			
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