

POC ACCEPTABLE
YES NO

Reviewed By: Debra Kappmeyer
Name

Facility: AMU
Name

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050444	(X2) Name: <u>Boalab Kamnitsky</u> Date: <u>12/5/13</u> A. BIRTH: <u>11/23/</u> B. WING: <u>11/23/</u> Notified By: <u>Debra Kappmeyer</u> Name	SURVEY COMPLETED 12/27/2013
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NAME OF PROVIDER OR SUPPLIER Mercy Medical Center	STREET ADDRESS, CITY, STATE, ZIP CODE 333 Mercy Ave, Merced, CA 95340-8319 MERCED COUNTY
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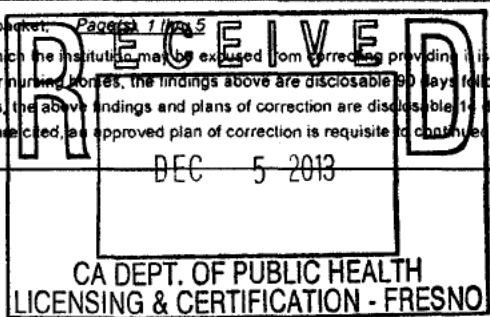
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	<p>The following reflects the findings of the Department of Public Health during an inspection visit:</p> <p>Complaint Intake Number: CA00318087 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 27709, HFEN</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>Health and Safety Code Section 1280.1(c): For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.</p> <p>DEFICIENCY CONSTITUTES IMMEDIATE JEOPARDY</p> <p>California Code of Regulations, Title 22, section 70215. Planning and Implementing Patient Care (b): The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission.</p> <p>Based on staff interviews, clinical record, and administrative document review, the hospital failed to assess and evaluate Patient 1's care when: (1)</p>		<p>Finding (1): Corrective Action: 1. Instituted new process for nurse(s) to call lab personnel if stat lab result is not received within one (1) hour of draw. Educated all nursing staff in August of 2012, on Heparin policy with 100% of participation by applicable nursing staff.</p> <p>At the time of the event, the system did not have the capability to order a timed lab. It was identified during a Failure Mode Effect and Analysis (FMEA) conducted in June of 2012, that there were only options for stat or routine tests when ordering an aPTT. An Information Technology (IT) solution was explored, and implemented with steps put in place for full implementation.</p> <p>Time lab option fully implemented on 3/6/2013, which includes the nurse to answer questions of whether the aPTT is related to a patient receiving heparin; if it is a priority draw; and the time of the draw is to occur. Training regarding new IT process was conducted on 3/5/13. With the timed draw, the nurse is more aware of when to follow up with the lab if the results are not received.</p> <p>Monitor: Electronically able to audit and monitor</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <u>Charles Kim</u>	TITLE VP, COO	(X6) DATE 12/3/13
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By signing this document, I am acknowledging receipt of the entire citation packet. Page 1 of 5

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 15 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 program participation.



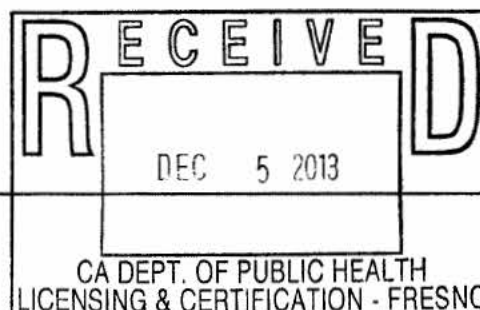
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	<p>Nursing staff did not follow up with the lab after the 3:29 a.m. Activated Partial Prothrombin Time (APTT- a test to determine the number of seconds it takes for a patient's blood to form a clot) lab draw; (2) The lab did not report the APTT critical results to the Registered Nurse (RN) until 7:24 a.m.; and (3) The observed abnormal signs and symptoms of Patient 1's reaction to the Heparin treatment (bleeding at the groin incision site, low blood pressure, and lethargy) were not reported to the Doctor in a timely manner as required by the hospital's heparin protocol. These failures resulted in a delay in Patient 1 receiving treatment for the Heparin overdose leading to a continued decline in condition. As a result, Patient 1 expired.</p> <p>Findings:</p> <p>On 9/23/13, during an interview, RN 2 stated that Patient 1 had a right and left heart catheterization (insertion of a thin flexible tube into a blood vessel to visualize the vessels of the heart) on [REDACTED] 12. RN 2 stated Patient 1 had a Heparin (drug used to prevent blood clots) drip infusion. RN 2 stated, "The heparin drip protocol [guidelines for administering Heparin] was not used prior to and during the heparin administration.</p> <p>The hospital's "Standard Heparin Order Sheet" (Heparin protocol) requires an Activated Partial Prothrombin Time (APTT- a test to determine the number of seconds it takes for a patient's blood to form a clot) be done before initiation of the Heparin and every 6 hours thereafter until the patient is in therapeutic range (a therapeutic level is a 60-95</p>		<p>continued ... response times after 3/6/13. Monitoring process includes lab director auditing times for aPTT ordered, drawn, resulted and registered nurse (RN) notification with 100% compliance. Any fallout is explored further with nursing documentation indicating lab called for pending results. Compliance rates were reported to the Regulatory Compliance Manager with greater than 90% compliance for last eight (8) consecutive months and ongoing. Results to be reported to Quality Management Committee, Medical Executive Committee, and Community Board monthly beginning December 2013 for four (4) consecutive months. Reevaluation of continued reporting process will be done at the completion of the four (4) months.</p> <p>Responsible Person (s): Director of Clinical Laboratory</p> <p>Finding (2): 2. Lab staff reeducated on the importance of following policy PC-213 Critical Results and Values and procedure for reporting critical lab values. Education consisted of recognizing normal range, elements required for an acceptable clot curve and verification of results prior to calling the appropriate nurse. Reeducation of policy COAG-PTT Performing aPTT on ACL TOP addressed all out of range aPTT</p>	

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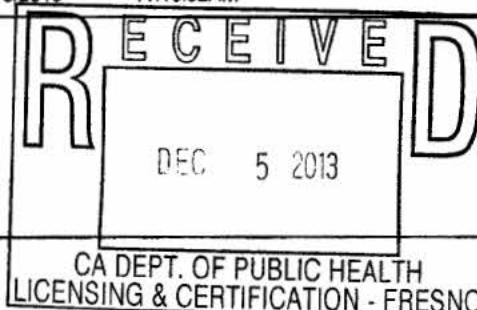
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	<p>second clotting time). The Heparin protocol also calls for the "...RN [registered nurse] to adjust the rate according to heparin dosing adjustment nomogram... [A chart used to calculate the heparin dose based on the patient's APTT] to maintain APTT between 60 to 95 seconds. ...Notify physician if bleeding event occurs or APTT > [greater than] 150 seconds. (A physicians order for action is required for APTT > 150 seconds.)"</p> <p>According to Lab Tests Online, a website produced by the American Association for Clinical Chemistry, "A PTT is often used to monitor standard (unfractionated, UF) heparin anticoagulant therapy [therapy to prevent blood clots]. Heparin is a drug that is given intravenously (IV) or by injection to prevent and to treat thromboemboli [blood clots]. When it is administered for therapeutic purposes, it must be closely monitored. If too much is given, the treated person may bleed excessively; with too little, the treated person may continue to clot."</p> <p>Patient 1's clinical record, dated [REDACTED]13, indicated the lab drew the APTT at 3:29 a.m. and the results were greater than 400 seconds. The lab considered the results erroneous and did not report them to the RN. Rather, the lab redrew the APTT at 4:59 a.m. on [REDACTED]12. Again, the results were greater than 400 seconds. Those results were not reported to RN 13 until 7:24 a.m., 4 hours after the initial APTT was drawn. At no time during those 4 hours did the RN attempt to call the lab to find out what the results were for the APTT.</p> <p>The Hospital's policy titled "Critical Results and</p>		<p>results are to be validated with the use of the "clot curve". Competency testing conducted on both policies October and November 2012 with 100% applicable to staff.</p> <p>Monitoring: 100% Timed aPTT labs are audited to ensure compliance with the time orders, critical results are verified per policy and the results are communicated with the nursing staff. Results to be reported to Quality Management Committee, Medical Executive Committee, and Community Board monthly beginning December 2013 for four (4) consecutive months. Reevaluation of continued reporting process with be done at the completion of the four (4) months.</p> <p>Responsible Person(s): Director of Clinical Laboratory</p> <p>Monitoring:</p> <p>Finding (3): Corrective Action: 3. New Post-Cardiac Catheterization Assessment policy (PC-410, Care of the Post Cath Lab, Special Procedures, or Intervention Radiology Patient) was created and approved on August 14, 2012. This new policy defines safe and efficient care for the patient following Cardiac Cath Lab, Special Procedures, or Interventional Radiology</p>	

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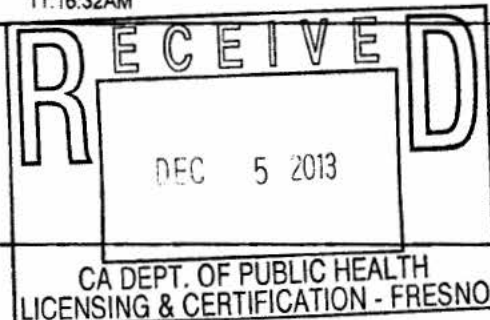
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	<p>Values", dated 2/11, indicated "when a critical test result is noted (see Critical Results - Attachment A), the nurse/LIP [Licensed Independent Practitioner] is notified by the Clinical Laboratory Scientist (CLS) within 15 minutes of the determination of that value." Attachment A of the policy indicates the critical value for an APTT is "100 seconds".</p> <p>On 9/25/13, during a concurrent clinical record review and staff interview, RN 1 stated that any changes in patient condition required the nurse to notify the doctor and document the information in the clinical record. RN 1 agreed there was no documentation of Patient 1's condition change until [redacted] 2 at 4 a.m. which indicated "NOTED PT [patient] HAS SWELLING AROUND SURGICAL SITE TO RIGHT GROIN, DRESSING SOAKED WITH BLOOD..." At 5:23 a.m. the nurse documented that the patient's blood pressure was 73/52 [a normal range is from 90/60 to 130/80]. Patient 1 had a history of high blood pressure and his blood pressure on admission was 158/81. The clinical record indicated the nurse did not report Patient 1's change in condition to the doctor until 6:30 a.m. on [redacted] 2 when there was no blood pressure present in the upper and lower extremities and the patient was lethargic.</p> <p>Under the Business and Professions code for Registered Nurses, Chapter 6 Article 2, Section 2725, Number (4) defines the practice of nursing as: "Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of</p>		<p>procedures and includes a graph of potential complications and actions to take if complications are identified. Telemetry unit specific competencies on this new policy were conducted with completion of 100% of applicable staff on 9/7/2012 to include post test. All nursing staff educated on PC-122 Chain of Command for Physician Access policy and PC-308 Patient Handoff Communication/SBAR at Nursing Quarterly Meeting in August 2012. Electronic competency completed with 100% compliance. The chain of command policy states which chain of command will be followed when a medically related problem is identified and there is either inadequate or no physician response. The patient communication policy addresses the use of SBAR (Situation, Background, Assessment and Recommendation) as the standard communication method when transferring care from one registered nurse to another. SBAR is a standardized communication mechanism to promote consistent communication when patient information is shared or a patient hand off occurs.</p> <p>Monitoring: Review of PC-410, Care of the Post-Cath Lab, Special Procedures, or Intervention Radiology Patient done annually with Telemetry unit nursing.</p> <p>Review of PC-122 Chain of Command for Physician Access policy and PC-308 Patient Handoff Communication/SBAR</p>	

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	<p>whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.</p> <p>The hospital's own policy and procedure entitled, "Heparin Infusion Protocol Policy number: MM-36 dated 7/11 indicated "1. Policy . . . Heparin Therapy will be initiated and administered according to the Standard Heparin Order Sheet . . . In an effort to reach and maintain therapeutic anticoagulation levels aPTT [APTT] test will be drawn every six (6) hours for monitoring and adjusting the heparin infusion."</p> <p>The hospital failed to assess and evaluate Patient 1's care when nursing staff did not monitor Patient 1's APTT while on the Heparin infusion and the lab did not report the APTT critical value within the 15 minutes required by hospital policy. In addition, Nursing staff did not report to the Doctor the abnormal signs and symptoms of Patient 1's reaction to the Heparin treatment (bleeding at the groin incision site, low blood pressure, and lethargy) until two and a half (2.5) hours after first observed. These failures resulted in a delay in Patient 1 receiving treatment for the Heparin overdose leading to a continued decline in condition. As a result, Patient 1 expired.</p>		<p>continued...</p> <p>policy review will be conducted annually with hospital re-orientation of all nursing staff. Retrospective audit and ongoing audit of 100% of post cardiac catheterization patients for assessment and documentation of findings and physician communication.</p> <p>Results to be reported to Quality Management Committee, Medical Executive Committee, and Community Board monthly beginning December 2013 for four (4) consecutive months. Reevaluation of continued reporting process will be done at the completion of the four (4) months.</p> <p>Responsible Person(s): Vice President of Nursing</p>	

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