CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050115	A. BUILDING _____ B. WING _____	03/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOMAR MEDICAL CENTER	555 E. VALLEY PARKWAY, ESCONDIDO, CA 92025 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a complaint/adverse investigation visit: Complaint Intake Number: CA00218239 - Substantiated Representing the Department of Public Health: [redacted], HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.1(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. Title 22 - 70263 Pharmaceutical Service General Requirements (g) No drugs shall be administered except by licensed personnel authorized to administer drugs and upon the order of a person lawfully authorized to prescribe or furnish. This shall not preclude the administration of aerosol drugs by respiratory therapists. The order shall include the name of the drug, the dosage and the frequency of administration, the route of administration, if other than oral, and the date, time and signature of the prescriber or furnisher. Verbal orders for drugs shall be given only by a person lawfully authorized to prescribe or furnish and shall be recorded		70263 Pharmaceutical Services	

Event ID: YNCK11 5/24/2010 9:32:44AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon Andrews — TITLE: Chief Nursing Officer — (X6) DATE: 6-11-10

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050115	A. BUILDING _____ B. WING _____	03/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOMAR MEDICAL CENTER	555 E. VALLEY PARKWAY, ESCONDIDO, CA 92025 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 1 promptly in the patient's medical record, noting the name of the person giving the verbal order and the signature of the individual receiving the order. The prescriber or furnisher shall countersign the order within 48 hours. (2) Medications and treatment shall be administered as ordered. On 2/9/10, Patient A was transferred from the Critical Care Unit (CCU) to the medical oncology floor, with a 3 channel IV (Intravenous) pump, that was programmed to deliver morphine (for pain control) at 3 ml (milliliters)/hour. On the medical oncology floor, the Registered Nurse, (RN 1) re-programmed the IV pump to deliver 100 ml/hour of morphine, instead of 3 ml/hour, which represented 33 times the amount the Patient A should have received. Patient A died at 5:10 P.M., twenty-six minutes after the IV infusion was stopped. The facility's policy did not allow for analgesics to be administered through a 3 channel IV pump on a medical oncology floor. Nursing failed to follow the policy for analgesia infusion on a medical oncology floor. The nursing staff did not change the IV morphine infusion from a 3 channel to a single channel IV pump when the patient was transferred. The IV pump was then programmed incorrectly by RN 1. Findings:		The RN assigned to primary care for this patient and who failed to correctly program the infusion rate of the narcotic medication was re-educated on the correct steps in programming the infusion pump and the standard for single channel pump usage outside the critical care unit. This RN was provided direct supervision when administering narcotic infusions for a period of time on her return to work. Person Responsible; Nursing Director A sweep of the patient care area was completed to insure that only single channel infusion pumps were in use. Person Responsible; Nursing Director The nursing staff on the involved unit were educated to the requirement to limit infusion their use to single channel infusion devices. Person Responsible; Nursing Director	2.20.10 2.12.10 3.1.10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050115	A. BUILDING _____ B. WING _____	03/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOMAR MEDICAL CENTER	555 E. VALLEY PARKWAY, ESCONDIDO, CA 92025 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 2 Patient A, a 62 year old female was admitted to the facility on 1/27/10. According to the Admission History and Physical, the patient presented to the Emergency Department with shortness of breath and significant vaginal bleeding. Patient A was diagnosed with a uterine malignancy and metastatic disease to the lungs. Patient A underwent a total abdominal hysterectomy on 2/2/10. The clinical summary on the surgical pathology report, dated 2/4/10, read, uterine carcinoma. On 2/6/10, the hospitalist (Physician 1) documented that the patient was having increased respiratory difficulty. The plan for the patient was to have palliative chemotherapy. On 2/7/10, Physician 2 documented that the patient had deteriorated to the point where palliative chemotherapy would be very difficult. On 2/8/10, Physician 3 discussed the plan with the patient, who elected hospice care and changed her code status to, "No Code", meaning that the patient would not want to be resuscitated in the event of cardiac failure. The physician wrote an order for a, "morphine drip titrate to comfort." Patient A transferred from the Critical Care Unit (CCU) to the medical oncology floor on 2/9/10. At 11:00 A.M. the patient's vital signs were documented as follows, per the flow sheet documentation: Blood Pressure 75/37, Pulse 92, Respirations 14 with 12 Liters of oxygen,		T This page is intentionally left blank.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050115	A. BUILDING _____ B. WING _____	03/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOMAR MEDICAL CENTER	555 E. VALLEY PARKWAY, ESCONDIOO, CA 92025 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEOED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 3 and oxygen saturation at 81%. At 5:10 P.M., the patient had no measurable vital signs and her pupils were fixed and dilated, according to the documentation on the flow sheet. RN 1 talked about Patient A and the events of 2/9/10 during an interview on 2/16/10 at 10:30 A.M. RN 1 stated that Patient A was transferred from the CCU with the morphine pump running at 3 ml/hour. According to RN 1, the patient appeared to be comfortable. At about 3:00 P.M., RN 1 said that she withdrew a 100 ml. bottle of morphine from the Pyxis machine (the automated drug delivery system) and went into Patient A's room to hang the new bottle. RN 1 stated that she was familiar with operating the 3 channel pump and that as the patient did not appear to be in any distress, she intended to hang the new bottle at the same rate of 3 ml/hour through Channel C. RN 1 said that she thought she had entered the volume to be infused as 100 ml and the rate as 3 ml/hour. RN 1 said the patient's family member, who had been with the patient most of the day, asked her to go to Patient A's room about an hour later because Patient A's respirations had changed. RN 1 said that when she entered the room and assessed the patient, the patient's respiratory rate was about 15 or 16 breaths per minute and irregular. RN 1 stated that she thought the patient might be having pain, so she went to increase the morphine rate. At that moment, RN 1 noticed that the bottle of morphine was nearly empty. RN 1 said that she		The RN assigned to primary care who failed to correctly program infusion rate of the narcotic medication was re-educated on the correct steps in programming the infusion pump and the standard for single channel pump usage outside the critical care unit. This RN was provided direct supervision when administering narcotic infusions. Person Responsible; Nursing Director A sweep of the patient care area was completed to insure that only single channel infusion pumps were in use. Person Responsible; Nursing Director The nursing staff were educated to the requirement to limit infusion pumps to single channel devices. Person Responsible; Nursing Director The RN in charge at the time of the medication error has been coached/counseled. Person Responsible; Nursing Director	2.12.10 3.1.10 2.20.10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050115	A. BUILDING _____ B. WING _____	03/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOMAR MEDICAL CENTER	555 E. VALLEY PARKWAY, ESCONDIDO, CA 92025 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 4 could not understand what had happened as the pump was showing that the morphine was infusing at 3 ml/hour, so she pressed the call light to get help. RN 2, the relief charge nurse for medical oncology, responded to the call and along with RN 1 tried to determine why the morphine bottle was empty. Unable to determine what had happened, RN 2 called for the House Supervisor, who in turn called RN 3 to assist. During a telephone interview with RN 3 on 2/16/10 at 11:45 A.M., RN 3 said that she responded to the House Supervisor's request to check on Patient A. When she entered the patient's room, she found RN 1 and RN 2 looking at the pump. Patient A had a pulse and was breathing at the time. RN 3 said that she made the decision to remove the pump from the patient's room in case it had malfunctioned. Patient A subsequently expired at about 5:10 P.M., per RN 3. The Chief Nursing Officer (CNO) was interviewed on 2/16/10 at 8:20 A.M. According to the CNO, the facility reviewed the printout of the activity history for the medication pump used to deliver Patient A's medications. The CNO stated that according to the information reviewed, when RN 1 hung a new bottle of morphine for Patient A, the RN programmed the pump to deliver 100 ml/hour instead of 3 ml/hour, which the patient had been receiving. The morphine was provided in a concentration		The infusion pump in use was isolated and the Bio Medical Engineering Department notified. The infusion pump was evaluated and determined to be functioning correctly. The infusion pump history was interrogated and the error in programing identified. Person Responsible; Director Bio Medical	2.16.10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050115	A. BUILDING _____ B. WING _____	03/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOMAR MEDICAL CENTER	555 E. VALLEY PARKWAY, ESCONDIDO, CA 92025 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 5 of 1 mg /ml. The CNO stated that the pump used to deliver the patient's morphine was a 3 channel pump. That type of pump had the capability to deliver three separate primary line medications, each through a different channel that was programmed individually. Patient A had an order for Normal Saline (NS) and morphine. The NS was ordered to run at 10 cc/hour, to keep the intravenous (IV) line open. The morphine was running at 3ml/hour when RN 1 hung the new bottle at 3:08 P.M., on 2/9/10. The NS was running through Channel A and the morphine through Channel C. The CNO also said that the policy at the facility did not allow for analgesics to be administered through a 3 channel pump on a medical oncology floor. According to the pump printout, on 2/8/10 at 11:40 A.M., a licensed nurse in the CCU programmed the pump to deliver morphine at 3 ml/hour through Channel C as a primary line. At 3:08 P.M. on 2/9/10, RN 1 hung a new bottle of morphine. RN 1 programmed the morphine to run through Channel C as a piggyback line and not a primary line. (A piggyback IV is connected to the primary line and the medication is delivered through the primary IV as an adjunct. The piggyback IV can be set to run at a different rate. When the piggyback fluid is finished, the pump automatically returns to the rate of delivery programmed for the primary line.) The pump printout showed that		A sweep of the patient care area was completed to insure that only single channel infusion pumps were in use. Person Responsible; Nursing Director The nursing staff were educated to the requirement to limit infusion pumps to single channel infusion devices. Person Responsible; Nursing Director	2.12.10 3.1.10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050115	A. BUILDING _____ B. WING _____	03/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOMAR MEDICAL CENTER	555 E. VALLEY PARKWAY, ESCONDIDO, CA 92025 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 6 RN 1 mistakenly set the rate of delivery for the piggyback to 100 ml/hour instead of 3 ml/hour. At 4:11 P.M. on 2/9/10, the IV piggyback had infused 99.8 ml per the printout and the pump reverted to delivering the morphine at 3 ml/hour as a primary line through Channel C. The delivery was stopped at 4:44 P.M. The policy and procedure entitled, "Pain: Analgesia Infusion" with an effective date of 1/3/08, was reviewed. According to the policy under, "III. Text/Standards Of Practice: E. Analgesia infusions will be administered via specialized or single channel volume controlled devices. Exception: CCU may use multichannel pumps to infuse IV drip analgesia." When Patient A was transferred from the CCU to a medical oncology floor, the patient was receiving morphine delivered at 3 ml/ hour via a multichannel pump. Nursing failed to transfer the infusion to a single channel pump. Nursing also failed to program the pump correctly and as a result, administered 100 ml of morphine to Patient A in one hour instead of 3 ml as intended. Patient A died one hour after the infusion was stopped. The facility's failure to use a single channel IV pump to deliver the intravenous infusion of morphine, and the failure to program the IV pump correctly is a deficiency that has caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an		Procedure "Pain Analgesia Infusion" has been reviewed and revised. Person Responsible; Nursing Director Two procedures are now in use; 1. Continuous Analgesia Infusion for End of Life. 2. Patient Handoff Communication Staff were educated on the standard of care identified in the procedures. Person Responsible; Nursing Director	4.20.10 3.1.10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050115	A. BUILDING _____ B. WING _____	03/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOMAR MEDICAL CENTER	555 E. VALLEY PARKWAY, ESCONDIDO, CA 92025 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 7 immediate jeopardy within the meaning of Health & Safety code section 1280.1 (c). 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 Safety Code Section 1280.1(c).		Daily unit rounds are performed to insure only single channel pumps are in use. Person Responsible; Nursing Director An audit of all continuous analgesia infusion for end of life care will be performed for a minimum of three months. Person Responsible; Nursing Director	4.1.10 and ongoing 4.1.10 and ongoing

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

Any deficiency stetement 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 survay 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.