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
	050534	A. BUILDING ____ B. WING ____	08/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John F. Kennedy Memorial Hospital	47111 Monroe St, Indio, CA 92201-6739 RIVERSIDE COUNTY

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The following reflects the findings of the Department of Public Health during an inspection visit:

Complaint Intake Number:
CA00286109 - Substantiated

Representing the Department of Public Health:
Surveyor ID # 28294, 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.

Abbreviations used in this document:

RN - Registered Nurse
& - and

Title 22 of the California Code of Regulations section 70717(f)(1):

Admission, Transfer and Discharge Policies.

(f) No patient shall be transferred or discharged solely for the purposes of effecting a transfer from a hospital to another health facility unless:
(1) Arrangements have been made in advance for admission to such health facility.

The plan of correction is prepared in compliance with federal regulations and is intended as JFK Memorial Hospital (the "hospital") credible evidence of compliance. The submission of the plan of correction is not an admission by the facility that it agrees that the citations are correct or that it violated the law.

Organization Minutes:
The confidential and privileged minutes are being retained at the facility for agency review and verification if required.

Exhibits
All exhibits including revisions to Medical Staff Bylaws, reviewed/revised or promulgated policies and procedures, documentation of staff and medical staff training/education are retained at the facility for agency review and verification upon request.

Penalty Number 250010926
The Governing Body is in receipt of the "Request For Plan of Correction for Immediate Jeopardy (IJ) Deficiencies" written by California Department of Public Health dated August 11, 2014. The Governing Body has taken the allegations of deficiency in the report seriously and continues to assume full responsibility for determining, implementing and monitoring policies governing the hospital's total operation and for ensuring that these policies are administered to protect and promote patient safety, protect patient rights and provide quality health care. We have reviewed the patients chart, discussed this event with Case Management, Social Services and the discharging physician. We have identified opportunities to improve our processes as it pertains to a patient safe discharge. The caregivers responsible for the care of this patient made every effort to transfer the

9/8/14

Event ID:YXPK11 8/11/2014 3:07:30PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE CEO (X6) DATE 8/27/14

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 9

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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Based on interview and record review, the facility (Facility A) failed to ensure a patient (Patient 6) was discharged for the purpose of effecting a transfer to another facility without first making advanced arrangements with that receiving facility (Facility B). Patient 6 was discharged from Facility A and told to go to the emergency department of Facility B, via private automobile. This placed Patient 6 at risk for increased health deterioration, harm and death. Additionally, Patient 6's vehicle had a mechanical breakdown on the way to Facility B and emergency services had to pick up Patient 6 from the side of the road in order to complete Patient 6's transfer to Facility B.

Findings:

On October 12, 2011, the record for Patient 6 was reviewed. Patient 6 was admitted to the facility (Facility A) on [redacted] 2011, with diagnoses including jaundice (yellow coloring of the skin which comes from bilirubin, a byproduct of old red blood cells) and liver failure (occurs when large parts of the liver become damaged beyond repair and the liver is no longer able to perform its physiological functions). Patient 6 did not have health insurance.

The "History and Physical," dated [redacted] 2011, indicated: "Social Services has been consulted for her issues and for discharge planning."

On [redacted] 2011, at 10:40 a.m., the "Hematology" and "Chemistry" results indicated

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patient to a tertiary care center for further care. Social Services and Case Management made every effort to find a receiving facility to no avail. The discharging physician recognized that the patient was very sick, continuing to decline and refusing hospice as an alternative for care. The required level of care was determined to be outside the scope provided by the hospital. After exhausting all resources to have this patient transferred to a higher level of care, and after discussion with the family, it was decided and agreed by the family to discharge the patient to the son so he could take his mother directly to Riverside County Hospital for continuation of care. The discharging physician contacted the hospital the patient was admitted to and was informed of the patient's status during her hospitalization there. At the time of this event, the physician felt it was the right course of action to take based on the patient's wishes to receive a higher level of care and the refusal to be placed on hospice.

Policy & Procedures:

The Chief Nursing Officer (CNO), Interim Case Management Director (ICM) and the Director of Clinical Quality Improvement (DCQI) reviewed the Policy and Procedure "Discharge of a Patient" effective revision date of 8/20/12. CNO, ICM and DCQI all agreed that a more comprehensive policy and procedure should be developed to reflect Conditions of Participation Guidelines 42 CFR 482.43, Discharge Planning. The revised policy and procedure will be placed on the next Medical Executive Committee and Governing Board Committee's agenda in September 2014 for final review and approval. — 8/20/12, 8/20/14

The Chief Nursing Officer, Interim Case Management Director and the Director of Clinical Quality Improvement reviewed the Policy and Procedure "Chain of Command" with effective date 8/6/12. There are no revisions required. — 8/6/12, 8/20/12

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Patient 6's White Blood Cell (WBC) count was 8.6 10e9/L (a unit of measure) and Bilirubin Total was 12.3 mg/dL (milligrams per deciliter).

[redacted] 2011, at 5:30 a.m., Patient 6's WBC count increased to 9.8 10e9/L and Bilirubin Total increased to 14.1 mg/dL.

The reference range for WBC count was 4.2 through 10.8 10e9/L (elevated WBC count occurs with infection, systemic illness), and the reference range for Bilirubin Total was 0.0 through 1.0 mg/dL (elevated Bilirubin Total occurs with liver damage, disease or failure).

On [redacted] 2011, at 7:15 p.m., the "Nursing Note" indicated Patient 6 was ready for discharge but that Patient 6 was "very weak; nauseated and started to vomit; her blood pressure was 88/42; HR (heart rate) 100". The physician was called and the physician requested to reverse the discharge and retain Patient 6 until she was more stable to send home.

On [redacted] 2011, at 9:17 a.m., the Case Management/Social Services notes indicated Case Management assisted with discharge planning for Patient 6.

On [redacted] 2011, at 5:06 a.m., Patient 6's WBC count increased to 16.3 10e9/L and Bilirubin Total increased to 15.7 mg/dL, which was considered a "critical value."

On [redacted] 2011, at 2:13 p.m., the Case

Other Corrective Actions:
A presentation was given to the Case Management Department on April 11, 2014 titled "Successfully Implementing New CMS Guidance on Discharge Planning Conditions of Participation for on-going education.

After a current review of this particular event, it has been identified there is an opportunity to develop a more comprehensive discharge planning policy and procedure that includes CMS Conditions of Participation regulatory requirements. A policy will be developed and will go to Medical Executive Committee and Governing Board in September 2014 for review and approval. Applicable staff and physicians will be educated on the revised policy and procedure and Case Management will monitor discharges through by conducted individual case reviews and refer any complex case review to Utilization Review Committee. Meeting Minutes will be reviewed and approved by Medical Executive Committee and Governing Board at their regularly scheduled meetings. — 9/1/2012

The Case Management Department continues to review discharge planning in collaboration with Social Services to ensure all patients have a safe discharge. The Case Management Director and/or designee will not allow any patient to be discharged that does not meet the safe discharge plan specific to the patient. Any patient that is difficult to discharge to a safe environment is reviewed by a multidisciplinary team and will not be discharged until a safe placement is secured. — 9/1/12

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Management/Social Services notes indicated Patient 6 "does not qualify for Medi-Cal per financial counsel".

On [redacted] 2011, at 10 p.m., the "Nursing Note" indicated Patient 6 was "very jaundice (sic) and abd. (abdomen) distended and round. Slight edema to lower ext. (extremities)".

On [redacted] 2011, at 12 a.m., the "Nursing Note" indicated that Patient 6 was "up to bathroom. Ambulation with assist. Very weak".

On [redacted] 2011, at 2:32 p.m., the Case Management/Social Services notes indicated Case Manager faxed referral to tertiary care center (specialized consultative health care center) on [redacted] 2011. Case Manager followed up with transfer center on [redacted] 2011, and faxed transfer forms to transfer center. On [redacted], 2011, transfer center informed Case Manager that the tertiary hospital (Facility B) was closed to outside transfers.

On [redacted], 2011, at 4:40 a.m., Patient 6's WBC count increased to 40.8 10e9/L and Bilirubin Total increased to 17.3 mg/dL, both were considered "critical values".

On [redacted] 2011, at 6:50 a.m., the "Nursing Note" indicated Patient 6 was made aware of her low blood pressure of 78/44 mmHg.

On [redacted] 2011, at 9:51 a.m., the Case Management/Social Services notes indicated

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A new Case Management Director was hired in August of 2014 to continue to work on improving our processes in discharge planning and will work with staff and physicians in discharge planning improvement efforts. All discharges will be reviewed by the Case Management Director and/or designee and will not allow any unsafe discharge to occur. The new Senior Leadership and the Governing Board members are involved in the hospitals patient safety program and will continue to have on-going involvement and oversight in Patient Safety and Quality of patient care at JFK Memorial Hospital.

Training:

Case Management Staff, Social Workers, Nursing and the Attending Physician that were involved in the care of this unfortunate patient, were informed of this event at the time it occurred. Case Managers, Social Workers and Nursing staff were reeducated by the hospital educator on the Discharge of a Patient Policy and Procedure with effective date 8/20/12 and the Chain of Command Policy and procedure with effective date 8/6/12 with an emphasis of escalating the chain of command when there is indication of an pending unsafe discharge that is not consistent with the hospital policy and procedures.

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physician to speak with patient regarding discharge. Patient 6 and family agreeable to follow up with care at (Facility B), son to drive patient to (Facility B). No other discharge needs noted.

On [redacted] 2011, at 11:50 a.m., the "Nursing Note" indicated Patient 6's respirations were 18 per minute and she was receiving continuous oxygen via nasal cannula; her blood pressure was 77/37 mmHg
(millimeters of mercury; normal blood pressure 120-129/80-84 mmHg); and she was receiving intravenous fluids (IV - fluids being given directly into a vein).

On [redacted] 2011, at 12:30 p.m., Patient 6 was discharged from the facility and accompanied by her son.

The "Progress Note" dated [redacted] 2011, indicated: "She really needs to start thinking about leaving here and going to another center for evaluation for liver transplant or if there are any other things that she can do".

The "Discharge Summary," dated [redacted] 2011, indicated: "Evaluation from GI (gastroenterology consult - digestive system) states that she needs to be transferred to a tertiary care center for further care;" also "Her best choice would be to be discharged from this hospital and be driven over to (Facility B) by her family to obtain possible care for her end-stage liver disease. We have been unable to transfer her for the last week to the tertiary care center".

Monitoring:
At the time of this event the hospital implemented Interdisciplinary Care Meetings that occurred Monday-Friday to review discharge needs and required resources for patients requiring discharge and/or transfer. More currently there are Daily Bed Huddles conducted twice a day to address our patient's needs to include discharge planning. In addition, Case Management conducts discharge planning for every patient to ensure our patient's receive a safe discharge.

Utilization Review Committee meets at a minimum 6 times per year to review utilization and any complex discharge planning needs of our patients. Committee minutes are reviewed by the Medical Executive Committee and Governing Board Leadership.

Responsible Person(s):
Chief Nursing Officer
Director Clinical Quality Improvement
Interim Director Case Management

Disciplinary Action:
Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures

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The "Discharge Instructions" dated [redacted] 2011, at 11:30 a.m., indicated the following:

(a) Next to the preprinted item: "Discharged to", the box "Home" was marked with an "X". Another box was also marked "Other" with Facility B listed in handwriting. A line was drawn through that entry.
(b) Next to the preprinted item: "Name of Facility", "pt (Patient 6) will go as O/P (outpatient) F/U (follow up) (Facility B)" was handwritten;"
(c) Next to the preprinted item: "Make Follow-up Appointment With Your Doctor-Dr.", Facility B was listed with "ASAP", handwritten for the timeframe. Facility B's telephone number was not listed on the document.

During an interview with Case Manager (CM) 1, on [redacted] 2011, at 3:32 p.m., she stated there was nothing else the hospital could do for Patient 6. The CM 1 stated she had contacted the county tertiary care center (Facility B) but they were closed to transfers and there was a long waiting list. She stated the family was taking Patient 6 to the Facility B that day to get into a clinic or the Emergency Department.

On April 18, 2012, at 11:15 a.m., an interview was conducted with RN 1. She stated Patient 6 was very jaundiced (yellow coloring of the skin and whites of the eyes caused by excess bilirubin in the blood). RN 1 stated the facility was trying to transfer Patient 6 but could not, "so the best to do" was to discharge Patient 6 and tell her to go to another facility. RN 1 stated Patient 6 was told she

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needed "to go right away to (Facility B)". In addition, RN 1 stated the telephone number to the other facility was not given to Patient 6 and her family, and was not included in the documentation.

The Ambulance Run Record dated [redacted] 2011, indicated the ambulance service received a telephone call at 1:45 p.m. (1 hour and 15 minutes after Patient 6 left Facility A), and Patient 6 stated "today she was released from hospital (per patient) due to no insurance and was told to follow up at (Facility B) and given directions to (Facility B) to go priv. (travel via private vehicle) despite pt (patient) weakness and low bp (blood pressure). Family states they were driving pt to (Facility B) when vehicle broke down and he was unable to continue and called 911. Pt was jaundiced on scene, feeling very weak, states dizziness".

The distance between Facility A and Facility B was 82.32 miles and the estimated driving time was 1 hour and 24 minutes (per MapQuest).

Patient 6 arrived via ambulance at Facility B, on [redacted] 2011, at 2:19 p.m.

The "Emergency Department" record at Facility B indicated Patient 6 was received at the facility on [redacted] 2011, at 2:25 p.m., with a pulse rate of 97 beats per minute; a blood pressure of 72/37 mmHg; abdomen distended; "very jaundiced" skin and eyes; "3+ edema (swelling)" of both legs; and an oxygen saturation of 93 percent while on two liters of oxygen per minute.

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	Patient 6 was admitted to the Intensive Care Unit (ICU), and died [redacted] 2011, at 4 p.m. Review of the "Death Summary", transcribed [redacted] 2011, revealed that Patient 6's medical problems, upon admission to Facility B on [redacted] 2011, included "septic shock (a condition in which overwhelming infection leads to life-threatening low blood pressure), acute respiratory failure, end-stage liver disease...right lower lobe pneumonia, and possible spontaneous bacterial peritonitis (bacterial infection in the abdomen). The patient did not improve and had a "very poor prognosis", and it was "determined that the patient that (sic) likely the patient would not recover...withdrawal of life support was initiated and the patient passed away on [redacted] 011". Facility A's policy and procedure entitled, "Discharge of a Patient" dated March 9, 2009, indicated its purpose was to: "ensure a safe and patient focused discharge". Facility A's policy and procedure entitled, "Chain of Command," dated February 3, 2009, indicated: "It is the professional responsibility of (Facility A) staff to question and/or clarify any practice, therapy, action or decision which he/she believes may be contrary to optimal patient care related to a specific patient".			

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	This facility failed to prevent the deficiency(ies) 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).			