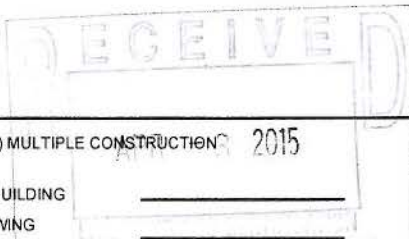


CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 052044	(X2) MULTIPLE CONSTRUCTION: 2015 A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER Vibra Hospital of San Diego	STREET ADDRESS, CITY, STATE, ZIP CODE 555 Washington St, San Diego, CA 92103-2289 SAN DIEGO COUNTY
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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: CA00397517 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 2434, 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>The following reflects the findings of the California Department of Public Health during the investigation of the self-reported incident # 397517</p> <p>Representing the California Department of Public Health: 29153</p> <p>Health and Safety Code Section 1280.1(a) Subject to subdivision (d), prior to the effective date of regulations adopted to implement Section 1280.3, if a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency</p>	<p>APR - 9 2015</p>	<p>Immediately upon discovering the patient's ventilator alarms sounding:</p> <ol style="list-style-type: none"> 1. A Rapid Response Team (RRT) was initiated, and the patient was ambu bagged with 100% oxygen. 2. The night doctor on duty arrived and ordered resuscitation measures. 3. The patient was transferred to the Intensive Care Unit (ICU) and connected to a new ventilator, handoff report was given to the Intensive Care Unit (ICU) Registered Nurse (RN) 4. Senior leadership: Chief Executive Officer, (CEO), Chief Clinical Officer, (CCO), Director of Quality, (DQM) was notified of the incident. A Root Cause Analysis (RCA) was initiated. 5. The family was notified of the change in condition. 6. The family was notified of the change of condition and updated regarding the findings of the Root Cause Analysis (RCA). 7. Patient continued to be monitored at an Intensive Care Unit (ICU) level of care. Neurology consultation and an 	<p>05/04/14</p> <p>05/05/14</p>

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Jameka Jones* TITLE: CEO (X6) DATE: 4/3/15

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 18

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.

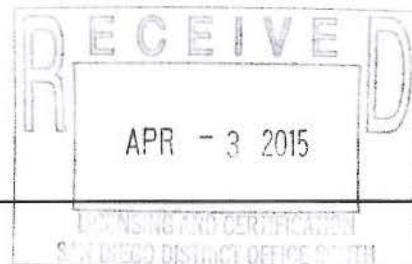
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	<p>constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars (\$25,000) per violation.</p> <p>(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>(d) This section shall apply only to incidents occurring on or after January 1, 2007. With respect to incidents occurring on or after January 1, 2009, the amount of the administrative penalties assessed under subdivision (a) shall be up to one hundred thousand dollars (\$100,000) per violation. With respect to incidents occurring on or after January 1, 2009, the amount of the administrative penalties assessed under subdivision (a) shall be up to fifty thousand dollars (\$50,000) for the first administrative penalty, up to seventy-five thousand dollars (\$75,000) for the second subsequent administrative penalty, and up to one hundred thousand dollars (\$100,000) for the third and every subsequent violation. An administrative penalty issued after three years from the date of the last issued immediate jeopardy violation shall be considered a first administrative penalty so long as the facility has not received additional immediate jeopardy violations and is found by the department to be in substantial</p>		<p>electroencephalogram (EEG) were done to further diagnose and treat neurological changes.</p> <p>Staff that was present on the unit during the incident was immediately interviewed in the Root Cause Analysis (RCA) and were provided with re-education by the Chief Clinical Officer (CCO) on their responsibility to respond to ventilator alarms. All staff education on responding to ventilator alarms was initiated by the Chief Clinical Officer (CCO).</p> <p>As an immediate response to this incident a Root Cause Analysis was initiated by the Director of Quality Management (DQM) and the Chief Clinical Officer (CCO). The following steps were immediately taken and all were completed by 05/06/14. To ensure there was no threat to the welfare, health and safety of patients.</p> <ol style="list-style-type: none"> 1. The subject ventilator was sequestered by the lead Respiratory Therapist (RT). The ventilator vendor was contacted and a Level 3 technician was requested for expedited inspection of the ventilator. 2. Respiratory Therapist (RT) 1 and Licensed Vocational Nurse (LVN) 1 were administratively suspended pending hospital investigation. 	<p>05/05/14</p> <p>05/06/14</p>

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	<p>compliance with all state and federal licensing laws and regulations. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section.</p> <p>1279.1. (a) A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law.</p> <p>(b) For purposes of this section, "adverse event" includes any of the following: (7) An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel or visitor.</p> <p>(d) "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.</p> <p>1279.1 (c) The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made.</p>		<p>3. All ventilator alarms (alarms on the ventilator machinery and remote ventilator alarms located in the corridor immediately outside the patient room) were verified by the Director of Respiratory Therapy (RT) as 100% operational and daily ventilator alarm checks were implemented.</p> <p>4. Ventilator alarms response drills were initiated by the Director of Respiratory Therapy (RT) to evaluate staff response time to ventilator alarms and to drive staff education.</p> <p>5. The Director of Quality Management (DQM) contacted the family of the patient to discuss initial findings of the Root Cause Analysis.</p> <p>Daily ventilator alarm drills were implemented by the Director of Respiratory Therapy (RT) to evaluate staff response to alarms to be ≤ 1 minute.</p> <p>Registered Nurse (RN) 1 and Licensed Vocational Nurse (LVN) 1 were administratively suspended pending hospital investigation of the incident.</p> <p>A pager assignment verification process was implemented by the Chief Clinical Officer (CCO) and Director of Respiratory Therapy (RT). At the beginning of each shift the Lead</p>	<p>05/06/14</p> <p>05/06/14</p> <p>05/07/14</p>

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	<p>The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made</p> <p>Title 22</p> <p>70213 Nursing Service Policies and Procedures (d) Policies and procedures that require consistency and continuity in patient care, incorporating the nursing process and the medical treatment plan, shall be developed and implemented in cooperation with the medical staff.</p> <p>70215 Planning and Implementing Patient Care (a) A registered nurse shall directly provide: (1) Ongoing patient assessments as defined in the Business and Professions code, section 2725 (b)(4). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area. (2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to the unlicensed staff, subject to any limitations of their licensure, certification, level of validated</p>		<p>Respiratory Therapy (RT) is now required to verify the pager assignments for all Respiratory Therapists (RTs) and the Nursing Supervisor is required to verify pager assignment for all nursing staff.</p> <p>A simulated patient room was established by the Chief Clinical Officer (CCO) to provide training to clinical staff regarding ventilator patients.</p> <p>Checking of ventilator connections was included in the simulated patient room training agenda and demonstrated and taught by the Director of Respiratory Therapy (RT) or his designee in group and 1:1 format.</p> <p>A multi-disciplinary Clinical Alarms Task Force was convened with a goal to address issues of alarm fatigue, implement best practice models for managing clinical alarms and to develop hospital policy further. The Clinical Alarms Task Force is led by the Director of Respiratory Therapy (RT) who reports updates from this task force to the Hospital Quality committee at routinely scheduled meetings. The Quality committee then provides data and information from the Clinical Alarms Task Force to Quality Assurance Performance Improvement (QAPI) and to the Medical Executive Committee (MEC) and to the Governing Board at routinely scheduled meetings.</p>	<p>05/09/14</p> <p>05/14/14 05/28/14 06/11/14 06/25/14 07/09/14 08/22/14 09/26/14 10/24/14 12/24/14 01/25/15 03/26/15</p>	

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	<p>competency, and/or regulation.</p> <p>(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>70403 Acute Respiratory Care Service General Requirement</p> <p>(a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.</p> <p>Based on observation, interview, record and document review, the hospital failed to ensure that multiple staff responded to Patient 1's ventilator alarm (an alarm on a breathing machine that is designed to alert staff to a possible medical emergency) for 12 minutes. One of the hospitals monitoring and electronic paging systems sent multiple pages/messages to Respiratory Therapist (RT) 1 and Licensed Vocational Nurse (LVN) 1 via a beeper (a small electronic device designed to notify staff of an important message), when Patient 1's ventilator readings deviated from preset parameters. RT 1 and LVN 1 did not respond</p>		<p>A Proactive Risk Assessment/Failure Mode Effects Analysis was completed to thoroughly review and revise the hospital process for responding to ventilator alarms.</p> <p>Respiratory Therapist (RT1), Registered Nurse (RN) 1, and Licensed Vocational Nurse (LVN) 1 were terminated. An Employer Mandated Report was made by the Chief Clinical Officer (CCO) to the licensing authorities regarding each of the terminated staff members.</p> <p>The hospital Performance Improvement Plan was reviewed and revised by the Director of Quality Management (DQM) and the Director of Respiratory Therapy (RT). The plan was amended to include a Respiratory Therapy (RT) performance measure for "Staff Response to Ventilator Alarms". The measure was identified as high risk, high volume and problem prone. A performance benchmark of ≤ 1 minute was established. The revised Performance Improvement Plan was approved by Quality Assurance Performance Improvement (QAPI), Medical Executive Committee (MEC), and the Governing Board. The Director of Respiratory Therapy (RT) now tracks and analyzes data regarding staff response to ventilator alarms on an ongoing basis.</p>	<p>05/22/14</p> <p>06/25/14</p>	

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	<p>to those pages/messages. In addition, the hospital's policy and procedure (P&P) was not developed to include clear expectations and guidelines for staff, pertaining to response times to ventilator alarms and other patient alarms. The hospital also did not have a written policy and procedure for staff which provided clear directions for reprogramming the centralized monitoring and paging system when a change in patient assignment occurred. As a result of these failures, Patient 1 sustained an anoxic brain injury (injury to the brain due to a lack of oxygen) with a poor prognosis. Patient 1 expired 28 days after the injury.</p> <p>Findings:</p> <p>On 5/7/14 at 1:45 P.M., an investigation was initiated as a result of a self-reported incident. Per the self-report, dated 5/7/14, a section of Patient 1's ventilator circuit (a series of tubes connected to a ventilator, a machine designed to move air in and out of the lungs) became disconnected. Patient 1 was found cyanotic (bluish discoloration of the skin due to not enough oxygen in the blood), unresponsive, and was transferred to the Intensive Care Unit (ICU).</p> <p>Patient 1 was admitted to the hospital on 2/11/14 with diagnoses that included hypercarbic respiratory failure (failure to eliminate carbon dioxide from the lungs and</p>		<p>The hospital policy titled, "Ventilator Patient Management" was revised by the Director of Respiratory Therapy (RT) and the Director of Quality Management (DQM) to include 'ventilator circuit connections shall be checked by staff after repositioning, bathing, and provision of care at the bedside of the ventilator patient'. The revised policy was approved by Quality Assurance Performance Improvement (QAPI), Medical Executive Committee (MEC) and the Governing Board committees.</p> <p>The hospital policy and procedure titled, "Oxinet System" was reviewed and revised by the Chief Clinical Officer (CCO), Director of Quality Management (DQM) and Director of Respiratory Therapy (RT) to include the pager verification process steps for staff to follow if they receive a page for a patient not assigned to them. The policy was approved by Quality Assurance Performance Improvement (QAPI), Medical Executive Committee (MEC), and Governing Board committees. Re-education was provided to Registered Nurse (RN), Licensed Vocational Nurse (LVN) and Respiratory Therapy (RT) staff. Education on responding to ventilator alarms was provided by the Chief Clinical Officer (CCO), Director of Respiratory Therapy (RT) and their designees in both group and 1:1 formats.</p>	<p>06/25/14</p> <p>06/27/14</p>	

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	<p>inadequate oxygenation), pulmonary hypertension (increased pressure in the arteries of the lungs) and right-sided congestive heart failure (the right side of the heart doesn't pump blood to the lungs normally), per the History and Physical (H&P), dated 2/11/14. Per the same document, Patient 1 required a ventilator. According to the "Patient Care Notes", dated 2/11/14 at 11:00 P.M., Patient 1 was assessed as alert and oriented to name, place and time.</p> <p>On 5/7/14 at 1:45 P.M., an interview was conducted with the Director of Quality Management (DQM) and the Chief Clinical Officer (CCO). The DQM and the CCO both stated that an internal investigation had been started in response to Patient 1's ventilator incident. The ventilator was discovered to be disconnected on 5/4/14 at approximately 3:30 A.M. The DQM and the CCO stated that the incident that involved Patient 1 was due to human error, and not a ventilator malfunction. The DQM and the CCO stated that two Registered Nurses (RNs), one of whom was the Charge Nurse (RN 3), were at the nurses' station and heard Patient 1's ventilator alarm, but did not respond. In addition, multiple pages were sent to RT 1's and LVN 1's beeper, and those pages went unanswered.</p> <p>On 5/7/14 at 2:25 P.M., an observation of the room Patient 1 occupied at the time of the ventilator incident was conducted. Patient 1's room was located in the medical/surgical unit</p>		<p>In addition to re-education of the revised "Oxinet System" policy, the Director of Respiratory Therapy (RT) developed and implemented an attestation for "Respiratory Therapy Critical Monitoring, Care and Coverage Policies" for all Respiratory Therapists (RTs). The attestation #2b. states, 'if there is a change in patient assignment, NOTIFY TELE_TECH'. All Respiratory Therapists (RTs) completed and signed the attestation.</p> <p>Pager verifications are reviewed daily by the Director of Respiratory Therapy (RT) and the Chief Clinical Officer (CCO). Any variances are addressed immediately. The Chief Clinical Officer (CCO) or his designee reports outcomes of the daily pager verifications to the Chief Executive Officer (CEO) and designated members of the Governing Board.</p>	<p>06/27/14</p> <p>06/30/14</p>

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	<p>and was 13 feet from the nurses' station, per the measurement of the hospital maintenance staff. An external ventilator alarm box, that was located on the wall outside the room, was tested. When activated, the alarm delivered a loud beeping sound and displayed a flashing red light. The alarm was audible and visible from the nurses' station.</p> <p>On 5/7/14 at 2:35 P.M., an interview was conducted with RN 6. RN 6 acknowledged that she had cared for Patient 1 prior to the ventilator incident. RN 6 stated that Patient 1 had been alert, able to communicate her needs by writing, and had been able to use the call light on her own. In addition, RN 6 stated that Patient 1 had been able to move her hands and arms, and was able to eat meals by mouth. RN 6 also stated that staff was required to respond immediately to a ventilator alarm.</p> <p>On 5/7/14 at 2:40 P.M., an interview was conducted with the Director of Respiratory Therapy (DRT). The DRT stated that if the oxygen saturation (O2 sat- the amount of oxygen in the blood) and/or heart rate (pulse) fell outside a patient's preset ventilator parameters, a page/message would be sent automatically via the Oxinet beepers, to the RT and nurse assigned to that patient. "Oxinet" was a centralized station and paging system that collected and distributed time sensitive patient data. The central station displayed</p>		<p>Ventilator alarm drills are ongoing, Outcome of alarm drills are provided to the Chief Clinical Officer (CCO) and by the Director of Respiratory Therapy (RT) on a daily basis including remediation done if results do not meet goal. The Chief Clinical Officer (CCO) or his designee provides alarm drill response data to the Chief Executive Officer (CEO) and designated members of the Governing Body on a daily basis. The Chief Clinical Officer (CCO) reports alarm response outcomes to Quality Assurance Performance Improvement (QAPI), Medical Executive Committee (MEC) and Governing Board committees on a routinely scheduled basis.</p> <p>The staff members responsible for all corrective action are the: Chief Executive Officer (CEO), Chief Clinical Officer (CCO), Director of Quality Management (DQM) and Director of Respiratory Therapy (RT).</p> <p>Monitoring of the following is ongoing and is now incorporated in to the Performance Improvement Plan and regular performance improvement monitoring of the Respiratory Therapy (RT) department.</p>	<p>06/30/14</p> <p>07/01/14</p>

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	<p>patient monitor data and had alarms, and was monitored by a technician. The system was designed to alert staff by sending electronic messages/pages to them via beeper devices. Each shift a Telemetry Technician (TT) was assigned to monitor the Oxinet system. A TT was a staff member who had specialized training to monitor and interpret cardiac rhythms and monitor other vital signs to include heart and respiratory rates, blood pressure and oxygen saturation levels, and ensure prompt notification of critical changes to appropriate staff. In addition, the TT was responsible for programming the individual staff beeper devices with their corresponding patient assignments.</p> <p>On 5/7/14 at 2:55 P.M., a joint observation of Patient 1 was conducted with RN 2. Patient 1 was transferred to the Intensive Care Unit (ICU) on 5/4/14, after her ventilator became disconnected and resuscitative measures were implemented. RN 2 stated that Patient 1 was currently non-responsive except to painful stimuli. Per RN 2, Patient 1 would open her eyes, but did not track or follow with her eyes (neurological assessment tool used to check brain function in an unresponsive patient). Patient 1 did not demonstrate any purposeful movement, and she was not on any medications that would inhibit purposeful movements. RN 2 stated Patient 1 had been administered Dopamine (intravenous medication to treat low blood pressure) intermittently since the ventilator incident to</p>		<p>~Staff response to ventilator alarms \leq 1 min ~Oxinet pager assignment verification ~Internal ventilator alarm function test ~External ventilator alarm function test</p> <p>Reporting of the staff response to ventilator alarm outcomes to the Hospital Quality Committee, Quality Assurance Performance Improvement (QAPI), Medical Executive Committee (MEC), and Governing Board committees will continue until 95% compliance is demonstrated and sustained for a minimum of six months.</p> <p>Monitoring of staff response to ventilator alarms is ongoing and is now incorporated in to the Performance Improvement Plan and regular performance improvement monitoring of the Respiratory Therapy (RT) department. Reporting of the staff response to ventilator alarm outcomes to the Hospital Quality Committee, Quality Assurance Performance Improvement (QAPI), Medical Executive Committee (MEC), and Governing Board committees and will continue until 90% compliance is demonstrated and sustained for a minimum of six months.</p>		

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	<p>maintain adequate blood pressure.</p> <p>On 5/7/14 at 3:30 P.M., a joint observation of the ventilator used by Patient 1, at the time of the incident, was conducted with the DRT. The DRT stated that the expiratory limb (section of tubing from the patient to the machine that filters carbon dioxide) became disconnected from Patient 1 on 5/4/14. Using the ventilator, the DRT demonstrated the ventilator's preset parameters that were set for Patient 1 on 5/4/14. The DRT then disconnected the expiratory limb. The ventilator alarm was heard within 4-seconds of the disconnection, and continued to alarm until reconnected.</p> <p>On 5/7/14 at 4:15 P.M., a joint review of the Oxinet report for 5/4/14, was conducted with the DQM. Per the report, beginning at 3:22 A.M. through 3:30 A.M., 23 pages/messages were sent to RT 1's beeper and 24 pages were sent to LVN 1's beeper via the Oxinet paging system. Per the report, the pages were sent due to Pt 1's elevated heart rate and declining oxygen saturation level. According to the DQM, RT 3 had been assigned to Patient 1 on the 5/4/14; however, the Oxinet paging system had not been programmed to send emergency pages/messages concerning Patient 1's status to RT 3. Instead, the Oxinet system had been programmed to send pages concerning Patient 1 to RT 1's beeper.</p>		<p>Oxinet Pager Assignment <u>Numerator</u>=Number of Oxinet pager assignments documented correctly. <u>Denominator</u>=100% of all Oxinet pager assignments</p> <p>Internal Ventilator Alarm Function Test <u>Numerator</u>=Total number of internal ventilator alarm function tests demonstrating the ventilator alarms working correctly <u>Denominator</u>=100% of all ventilator alarm function tests performed</p> <p>External Ventilator Alarm Function Test <u>Numerator</u>=Total number of external ventilator alarms tested showing the external alarms working correctly <u>Denominator</u>=100% of all external ventilator alarms tests performed.</p> <p>Ventilator Alarm Drill Response Time ≤ 1 min <u>Numerator</u>=Number of ventilator alarm drill response times ≤ one minute <u>Denominator</u>=Total number of ventilator response time drills performed.</p>	

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	<p>On 5/8/14 at 12:51 P.M., an interview was conducted with RN 1. RN 1 was partnered with LVN 1 on 5/4/14 because an LVN's scope of practice limited her ability to perform certain nursing care duties for Patient 1. However, both RN 1 and LVN 1 were responsible for the patient's care. RN 1, being the Registered Nurse, had the ultimate responsibility for Patient 1's care according to RN 1. RN 1 stated that she was at the nurses' station and heard Patient 1's ventilator alarming, but did not respond to the alarm. RN 1 stated, "It was just the vent alarm, it's not like the oxygen saturation alarm, so I didn't think anything of it". RN 1 stated that she saw LVN 1 go into Patient 1's room. Per RN 1, LVN 1 then came out of Patient 1's room and called RN 1 for help. RN 1 went into Patient 1's room and found the patient unresponsive. RN 1 stated that this all occurred at approximately 3:30 A.M. on 5/4/14.</p> <p>On 5/8/14 at 1:20 P.M., an interview was conducted with RN 3 (the Charge Nurse on 5/4/14). RN 3 stated that she was at the nurses' station at approximately 2:45 A.M. on 5/4/14. Per RN 3, at that time, she heard "multiple" alarms sounding on the unit. RN 3 stated that she did not respond to any of the alarms, and she was unclear if any of the alarms were from Patient 1's room, because she was "distracted" by the report she was</p>				

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	<p>receiving from another nurse. RN 3 stated she saw LVN 1 enter Patient 1's room at some point. RN 3 stated that Telemetry Technician 2 (TT 2) telephoned the nurses' station (unsure of the time) and informed her that Patient 1 was "desaturating" (oxygen level in blood decreasing). Immediately following the phone call from TT 2, RN 3 heard LVN 1 yell from Patient 1's room, "I need help, call Rapid Response (a process when a team of licensed staff responds to a medical emergency)." RN 3 stated another nurse called the Rapid Response Team, and she went to assist LVN 1 and RN 1.</p> <p>On 5/8/14 at 2:00 P.M., an interview was conducted with LVN 1. LVN 1 stated that, while she was providing care and repositioning Patient 1, she received a page/message via her beeper at 3:11 A.M., notifying her that Patient 1 had an increased pulse rate. LVN 1 denied receiving any other pages via her beeper for Patient 1 after 3:11 A.M. LVN 1 stated that at some point during her shift (was unable to provide the exact time), RN 3 told her that Patient 1 was desaturating. LVN 1 stated after being informed that Patient 1 was desaturating, she went into Patient 1's room and found her unresponsive and cyanotic. LVN 1 stated that she yelled for a Rapid Response to be called.</p> <p>On 5/8/14 at 3:21 P.M., an interview was conducted with RN 5 (a resource nurse who</p>				

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	<p>provided staff meal and rest breaks on 5/4/14). RN 5 stated she heard the request for the Rapid Response Team called via the overhead announcement system, and went to Patient 1's room. RN 5 stated that RT 3 arrived a few seconds after she did. Per RN 5, RT 3 informed her that the expiratory limb of Patient 1's ventilator was on the floor, and was disconnected at the Y connector (a Y shape tube that attaches the inspiratory and expiratory limbs of the ventilator to the patient).</p> <p>On 5/8/14 at 3:43 P.M., an interview was conducted with TT 2. TT 2 was assigned to the Oxinet system on 5/4/14. TT 2 stated that at approximately 3:00 A.M., the Oxinet paging system was alarming for Patient 1 due to a low oxygen saturation level. TT2 stated that she immediately called the nurses station, but no one answered. TT 2 stated she called the nurses station a second time. She could not recall the time between calls. TT 2 stated that RN 1 answered the second call and was informed of Patient 1's low oxygen saturation alarm. TT 2 stated that when Patient 1's oxygen saturation continued to drop, she called the nurses station a third time. TT 2 stated that RN 3 answered the phone and was informed of Patient 1's continued drop in oxygen saturation. TT 2 stated that shortly after the call ended, she heard the call via the hospital's overhead announcement system for the Rapid Response Team.</p>			

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	<p>On 5/8/14 at 4:22 P.M., an interview was conducted with RT 1. RT 1 denied that Patient 1 was assigned to his "workload (#2)" on 5/4/14. RT 1 stated that he had received pages via his beeper from the Oxinet system for his assigned patients that night, but denied receiving any pages/messages for Patient 1. RT 1 stated, "It didn't matter if I didn't get a page for Patient 1, the nurses get the pages too and they should have responded." RT 1 denied any assignment change occurred during his shift. RT 1 stated that the previous shifts "workload" assignments would sometimes "roll over" to the oncoming shift.</p> <p>On 5/8/14 at 4:46 P.M., a joint review of the RT workload assignments for 5/4/14 was conducted with the DRT. The DRT stated that the workload assignments for the oncoming shift were done by the RT lead, on the prior shift. The DRT stated a copy of the workload assignments was sent to the TT each shift. Per the DRT, the TT would then program the RT's Oxinet beepers with their assigned patients so the pages/messages were automatically sent to the RT when preset ventilator parameters went out of range. A review of the RT worked assignments, dated 5/3/14 for the day shift indicated that Patient 1 was assigned to "workload # 2." A review of the workload assignments, dated 5/3/14 for the night shift indicated that Patient 1 was assigned to "Workload #3", which was assigned to RT 3.</p>				

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	<p>On 5/8/14 at 4:55 P.M., an interview was conducted with RT 3. RT 3 stated that Patient 1 was assigned to her workload, due to Patient 1's preference for female caregivers. RT 3 stated LVN 1 called her cellular phone to inform her that Patient 1 requested to be suctioned. RT 3 stated that she asked LVN 1, "Why are you calling me for suction?" RT 3 stated that LVN 1 responded, "I am busy and the patient is desaturating". RT 3 stated that she heard the Rapid Response Team called via the overhead announcement system shortly after the telephone call from LVN 1 ended. RT 3 stated that she went to Patient 1's room and noticed the expiratory limb of the ventilator circuit was disconnected at the Y-connector. RT 3 denied that she received any pages for Patient 1 on her shift. This was consistent with the Oxinet report which revealed that messages/pages had been sent to RT 1.</p> <p>On 5/13/14 at 3:51 P.M., an interview was conducted with the Unit Clerk (UC), who was also a TT. The UC stated that she took over TT 4's responsibility of monitoring the telemetry and Oxinet system at 5:30 P.M. on 5/3/14. The UC stated that she programmed the beepers with the patient workload assignments for the RNs, LVNs, and RTs for the evening shift of 5/3/14 which included the night shift (early hours of 5/4/14). The UC stated that she assigned Patient 1 to RT 1's</p>			

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	<p>beeper, per the workload assignment sheet she received from the day shift RT lead.</p> <p>On 5/15/14 at 7:39 A.M., a review of the hospital's policy and procedure titled, "Ventilator Patient Management", dated 3/13, was conducted. The policy and procedure indicated that, "All healthcare staff will respond to ventilator alarms to determine cause and notify Respiratory Care when needed". This policy did not provide clear direction and guidance for staff regarding the urgency of, or specified timeframes for, responding to ventilator alarms. The Nursing staff and RT staff did not respond to Patient 1's ventilator alarm for 12 minutes.</p> <p>On 5/15/14 at 8:50 A.M., a review of the hospital's document titled "Plan for the Provision of Patient Care" was conducted. The document indicated, "Respiratory Care/Cardiopulmonary: The Respiratory Care department will provide the following therapeutic and diagnostic services to inpatients: Ventilator Management. These services will be provided in accordance with and influenced by standards of care, standards of practice...."</p> <p>There was no written policy or procedure concerning the notification to the TT of an assignment change. However, on 5/12/14 at 10:02 A.M., during an interview with the DQM and the CCO, the CCO stated that the process</p>			

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	<p>of informing the Telemetry Technicians of any reassignments was not a written policy but was the expected practice. In addition, the CCO stated that when RT 1 did not respond to his beeper concerning Patient 1, it was not the professional standard of care. Both the DQM and the CCO acknowledged multiple staff did not respond to Patient 1's audible ventilator alarm. In addition, RT 1 and LVN 1 did not respond to numerous pages that were sent to them via the Oxinet beepers concerning the changes in Patient 1's oxygenation and heart rate status.</p> <p>On 5/4/14, when Patient 1's ventilator became disconnected and alarmed for 12 minutes due to the patient's dangerously low oxygen level, two RNs, who acknowledged hearing those alarms, failed to respond. The patient was found cyanotic and unresponsive, emergent interventions were implemented, and Patient 1 was transferred to the ICU. During an interview with the patient's primary physician, on 5/15/14 at 9:04 A.M., the patient's primary physician stated that Patient 1 had a poor prognosis.</p> <p>On 5/5/14 at 4:53 P.M. the Vice President of Clinical Operations, the Chief Compliance Officer, the Director of Quality Management, the Corporate Director of Licensing and Accreditation, the Chief Executive Officer, the Vice President of Hospital Operations, and the Vice President of Licensing and Accreditation were informed of the potential for an</p>			

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	<p>Administrative Penalty to be issued as a result of these violations.</p> <p>On 7/23/14 at 6:03 P.M., an interview was conducted with the CEO. Per the CEO, Patient 1 expired on 6/1/14, 28 days after sustaining the anoxic brain injury.</p> <p>The facility's noncompliance with these requirements, jointly, separately or in any combination, 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 Safety Code Section 1280.1.</p> <p>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).</p>				

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