CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) MULTIPLE CONSTRUCTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
	A. BUILDING: _____ B. WING: _____	050575

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Gardens Medical Center	**21530 Pioneer Blvd Hawaiian Gardens, CA 90716 LOS ANGELES COUNTY**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ID PREFIX TAG
	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00724209 - Substantiated Representing the Department of Public Health: Surveyor ID # , HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of a facility. Health and Safety Code Section 1280.3(g): 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. Medication Error Health & Safety Code 1279.1(b)(4)(A) (b) For purposes of this section, "adverse event" includes any of the following: (4) Care management events, including the following: (A) A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong		

drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

22 CCR § 70213. Nursing Service Policies and Procedures.
(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.
(b) Policies and procedures shall be based on current standards of nursing practice and shall be consistent with the nursing process which includes: assessment, nursing diagnosis, planning, intervention, evaluation, and, as circumstances require, patient advocacy.
22 CCR § 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 unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation.
(3) The assessment, planning, implementation, and evaluation of patient education, including ongoing discharge teaching of each patient. Any assignment of specific patient education tasks to patient care personnel shall be made by the registered nurse responsible for the patient.
(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.
(c) The nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, the patient's

coordination with the patient, the patient's family, or other representatives, when appropriate, and staff of other disciplines involved in the care of the patient.
(d) Information related to the patient's initial assessment and reassessments, nursing diagnosis, plan, intervention, evaluation, and patient advocacy shall be permanently recorded in the patient's medical record.
22 CCR § 70263(g) (2)
(2) Medications and treatments shall be administered as ordered.

Based on interview and record review, the facility failed to:
1. Ensure that one of one sampled patient (Patient 1) received the correct dose of fentanyl (a powerful pain reliever with a high risk for death if taken in large amounts) as ordered by the physician.
2. Follow physician's order and place the medication through a central line.
3. Follow the policies and procedures for administration of medication.
4. Train their contracted nursing staff on how to use the intravenous (IV) infusion pumps (a machine used to give medication to a patient through their veins at a controlled rate) before giving them a patient assignment as required by the regulations and policy and procedures.

The hospital's failure to ensure that the patient received the correct dose of medication had the possibility to seriously harm the patient and cause the patient to suffer serious adverse effects.

Findings:

A review of Patient 1's "Patient Information Sheet," not dated, indicated the facility admitted Patient 1 on 1/28/21 for pneumonia (an infection in one or both lungs), hypoxia (a condition in which the body or a part of the body is not getting enough oxygen), and suspected COVID-19 (coronavirus disease 2019, a serious disease resulting from a new virus that spreads easily from person to person).

A review of Patient 1's "History & Physical (H&P)," dated 1/28/21, indicated that the patient was transferred from a previous hospital for COVID pneumonia.

A review of Patient 1's "Additional Nurse's Notes," dated 1/30/21, indicated that the patient's clinical condition deteriorated, and the patient was intubated "around 11:15 (a.m.)."

A review of Patient 1's "Physician's Orders," dated 1/30/21, indicated that the doctor ordered intubation (the process of inserting a tube into the patient's airway to help maintain breathing if the patient is not able to breathe by themselves) and central line (a line that is inserted in a large vein that is close to the heart so that medication can be given quickly) placement. The order further indicated that the physician a fentanyl infusion with a concentration of 1000 micrograms (mcg) per 100 milliliters (mL) at a rate of 25 mcg per hour intravenously (IV, into the veins) at 11:20 a.m. The Physician's Orders also indicated to titrate the fentanyl infusion by 25 mcg every 30 minutes for signs and symptoms of pain.

A review of Patient 1's "Variance Report," dated 2/4/21, indicated, "Fentanyl was ordered verbally during a procedure. The verbal order was communicated to a staff nurse not in the procedure. The order was written by 2 different staff nurses. The bag was mixed by another staff nurse at 1000 mcg/100 mL. It was hung by 2 others and handed to [Registered Nurse (RN) 1]. [RN 1] started it and eventually titrated it to 100 mcg/min. An hour later, the bag was empty, and it was noted that the med was programmed at 100 mcg/100 mL instead of 1000 mcg/100 mL."

A review of the facility's "Opportunities for Improvement" document, not dated, indicated, "Fentanyl drip should have lasted 10 hours but was infused via pump in 90 minutes."

A review of RN 1's written and signed declaration, dated 2/4/21, indicated, "I had never received training on the pumps, so the other nurses set them up for me. From what I could see, [RN 2] and [RN 3] placed the med on the pump and set it up for me, the pump was then rolled into the room… I had clarified starting the pump at 100 mcg/hr as the patient was over breathing the ventilator and appeared uncomfortable, so I increased the titration. . . An hour later, roughly, the IV pump was alarming for another bag. [House Supervisor]

alarming for another bag. [House Supervisor] and I had inspected it to find the entire bag was administered. We then saw the pump was set to 100 mcg/100 mL. So, when I changed the rate to 100 mcg/hr, it gave the entire bag."

A review of RN 3's written and signed declaration, dated 2/4/21, indicated, "Order was for Fentanyl 1000 mcg/100 mL. Another nurse mixed the medication. I programed the pump concentration at 100 mcg/mL with the additional 0 missing. The pump was then left in the corner as the patient was still getting procedures done. Another nurse then connected it to the patient and ran the medication. The medication was run through a peripheral IV in the right hand."

During an interview on 2/4/21, at 8:48 a.m., with the House Supervisor, the House Supervisor stated, "A bunch of nurses got their hands on the pump, but long story short, it was ordered at 1000 mcg/100 mL, but the pump was set to 100 mL/hr."

During an interview on 2/4/21, at 9:24 a.m., with RN 1, RN 1 stated, "I titrated to 100 mg, it gave the entire bag of fentanyl to him in one hour." RN 1 further stated, "I am using pumps, monitors I have never been trained on. No education available to me or any of the other staff."

During an interview on 2/4/21, at 10:32 a.m., with RN 2, RN 2 stated, "I started here on the 26th. I luckily worked with the IV pumps in a previous facility, so I was pretty aware of it, but I did have to help other nurses because they had absolutely no training." When asked if she received IV pump training from the facility, RN 2 stated that there was no training and no competencies.

During an interview on 2/4/21, at 10:56 a.m., with RN 3, RN 3 stated, "I did not get IV pump orientation." RN 3 further stated that the only equipment she received training on was the ventilator (a machine that helps the patient breathe or breathes for the patient) and the Pyxis (a machine that automatically dispenses medication).

During an interview on 2/4/21, at 12:04 p.m., with RN 3, RN 3 stated, "I put the numbers in

the pump. I was learning how to program it on the pump. I left a 0 out." RN 3 stated that instead of programming the correct ordered concentration of 1000 mcg/100 mL, she programmed 100 mcg/100 mL. RN 3 further stated that the patient was to have a central line, but at the time the medication (fentanyl) was administered, the central line was not in place, so the RN used the peripheral IV access. If this medication was administered through the central line as indicated in the MD order, the medication would have caused or likely to cause serious injury or death to the patient.

During a concurrent interview and record review, on 2/4/21, at 11:39 a.m., with RN 1 and the House Supervisor, Patient 1's "Medication Administration Record (MAR)," dated 1/30/21 was reviewed. The MAR indicated that the first administration of the fentanyl drip was documented at 1900 (7:00 p.m.) but continued from the previous shift. RN 1 stated that she was not trained on how to chart on paper and did not know how to back chart the medication error or the titration. The House Supervisor stated that in the chart, it appeared as if the patient did not receive the medication at the time it was ordered.

A review of the House Supervisor’s written and signed declaration, dated 2/4/21, indicated that after they discovered that the bag was empty, she and RN 1 assessed the patient and found that the patient’s blood pressure was within normal limits and the heart rate was unchanged. The written and signed declaration also indicated, “I went into [the Chief Nursing Officer’s] office and asked if any of the nurses had been in-serviced on the pumps. . .I explained I personally was never in-serviced, nor had I seen a rep since I arrived 1/25/21. I informed her then of the medication error with the pump and fentanyl and asked that she please call the rep and ask her to come back because this was clearly and issue.”

During an interview with the Administrator, on 2/5/21, at 11:21 a.m., the Administrator stated they were working on the competencies for the IV pump.

A review of the facility's policy and procedure (P&P) titled "Medication Administration," dated

	(P&P) titled ¨Medication Administration,¨ dated 9/1/18, indicated, "Medications shall be administered only upon the order of physicians, dentists, or podiatrists, who are members of the medical staff, are authorized members of the house staff or have been granted clinical privileges to write such orders and under the guidelines of their respective scopes of practice. . .Prior to the administration of high-alert medications, such as heparin, insulin, digoxin or chemotherapy agents, the amount ordered and amount prepared must be checked by two (2) licensed nurses)." 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 1280.3(9). 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 1280.3(g).			

EVENT ID: R1HU11 03/21/2024 4:10:47 PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determ that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following th 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 follo the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued prograr participation.

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