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
	050441	A. BUILDING _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanford Health Care	**300 Pasteur Dr, Stanford, CA 94305-2200 SANTA CLARA 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 an inspection visit: Complaint Intake Number: CA00928274, CA00897679 - Substantiated Representing the Department of Public Health: Surveyor ID # 3028, 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 1280.3(h): 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. REGULATORY FINDING(S): California Health and Safety Code section 1280.3 (h) (h) 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. California Code of Regulations, Title 22, section 70215 (a)(2), section 70215 (b) Planning and Implementing Patient Care A registered nurse shall directly provide: (a)(2) The planning, supervision, implementation,			

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

By signing this document, I am acknowledging receipt of the entire citation packet, *Page(s). 1 thru 8*

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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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.

(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.

Based on interview and record review, the facility failed to identify and communicate the presence of Patient 1's esophageal temperature probe (a device used to measure core body temperature) prior to a magnetic resonance imaging (MRI, a medical imaging procedure that uses strong magnetic fields to create images of the inside of the body).

This failure resulted in Patient 1 suffering burn injuries to the lips, mouth, and tongue during the MRI.

FINDINGS:

On 11/5/24, an unannounced visit was conducted at the facility to investigate a complaint and facility reported incident.

Review of Patient 1's Vascular Surgery Progress Note, dated 4/25/24 indicated the patient was

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	admitted to the facility on 4/6/24 with diagnoses including a ruptured abdominal aortic aneurysm (AAA, enlargement of the aorta, the main blood vessel that delivers blood to the body). The note indicated Patient 1 underwent a procedure to repair the aneurysm, was intubated (a medical procedure that involves inserting an endotracheal tube [ETT] into a person's airway to help them breathe), sedated (in a state of calmness, relaxation, or sleepiness caused by certain drugs) and required continuous renal replacement therapy (CRRT, a type of dialysis that removes wastes, toxins, and excess fluid from the body). Review of Patient 1's Flowsheets, from 4/6/24 to 5/28/24, indicated that on 4/22/24, at 10 a.m., Patient 1 had a temperature of 38.4 degrees Celsius (measurement of temperature; also 101.1 degrees Fahrenheit) and the temperature source (how the temperature was taken) was "esophageal." Patient 1's Flowsheets also indicated on 4/25/24, the patient temperature source was "esophageal" at 2 a.m., 3 a.m., 4 a.m., 5 a.m., and 6 a.m. It also indicated on 4/25/24, at 7 a.m., there was no temperature source documented. Review of Patient 1's Comprehensive Critical Care Notes, dated 4/25/24 indicated that on 4/24/24, Patient 1 had an MRI of the brain and it was recommended that Patient 1 have an MRI of the spine. Review of Patient 1's Screening Form Questions, dated 4/25/24, indicated Patient 1 had an appointment scheduled on 4/25/24, at 3 p.m. for MR			

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	Thoracic and Lumbar Spine (middle and lower section of the backbone). The form also indicated the answer to the question, "Does your patient have a temperature sensitive Foley?" was "No." Review of Patient 1's Study Result MR Thoracic and Lumbar Spine indicated the patient's exam ended on 4/25/24, at 5:25 p.m. Review of Patient 1's Flowsheets, dated 4/25/25 indicated Patient 1 had wounds to the left lateral (to the side) lip and mouth, first assessed on 4/25/24, at 7:25 p.m. The Flowsheets also described the mouth wound as "tongue white blistering" and that the surrounding skin was edematous (swollen with fluid). Review of Patient 1's Comprehensive Critical Care Note, dated 4/26/24, indicated, "... esophageal temp probe found melted in mouth with wire exposed, some burns noted along lips ..." Review of Patient 1's Otolaryngology - Head and Neck Surgery Consult History and Physical, dated 4/26/24, indicated, "Yesterday, patient was taken to radiology to undergo an MRI T and L spine. Unfortunately, an esophageal temperature probe was kept in place for the duration of the scan (approximately 90 minutes). Once the patient was received, primary team noticed the probe fused to his upper left lip, ETT and tongue. ENT consulted for evaluation of oral and OP burns and management." The consult also indicated pertinent findings of a flexible fiber laryngoscopy, which were: "temp probe adhered to ETT; Burns involving the left upper lip;			

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burn with fibrinous tissue involving 40% of central tongue, 30% of soft and hard palate [roof of the mouth], right base of tongue."

Review of Patient 1's Plastic and Reconstructive Surgery History and Physical/Consult Note, dated 4/26/24 indicated, "Plastic surgery was consulted to evaluate the lip burn ... Will require surgical reconstruction pending clinical stability."

During an interview on 11/7/24, at 11:30 a.m., the MRI Manager (MRIM) stated when a patient has an order for an MRI, a screening form is generated for a nurse to complete. She stated once the form is completed, the MR technologist (MRT) proceeds to review the answers and ask questions as needed. She stated when the patient is taken to the department, the MRT does a visual check on the patient before the MRI procedure. The MRT also waves a mental detecting wand over the patient to identify any unknown metal before the procedure. The MRIM stated Patient 1 was on a ventilator and the nursing team took the patient to get an MRI. She stated after Patient 1's MRI, the MRIM was alerted that there was a concern with a burn. The MRIM stated a nurse did an assessment and saw that Patient 1 still had an esophageal temperature probe in place. The MRIM stated they reviewed the screening form the facility used and identified that the form only asked if the patient had a foley catheter (a tube inserted in the urinary tract into the bladder to drain urine) temperature probe. She stated the form did not ask about other temperature probes, like an esophageal probe. The MRIM stated in an ideal world, the esophageal temp probe should

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have been identified by the MRT during the visual check. She stated the MRT did not realize there was an esophageal temp probe in place because it was white and looked like it was part of Patient 1's ET tube/respiratory equipment. She stated the MRI generated heat because of the metal in the esophageal probe, which caused the plastic on the probe to melt, and resulted in Patient 1's burns in his mouth.

During an interview on 11/8/24 at 8:55 a.m., the MRT involved in Patient 1's 4/25/24 MRI stated the responsibility of an MRT is to confirm verbally with the nurse that the patient did not have any devices that could not go in the MR scanner. The MRT stated he confirmed with Patient 1's nurse that the patient did not have any devices that could not go in the MR scanner.

During an interview on 11/8/24, at 10 a.m., Registered Nurse (RN) E stated he was Patient 1's primary nurse on 4/25/24. RN E stated he was not aware Patient 1 had an esophageal temperature probe. He stated he only found out about Patient 1's esophageal probe after Patient 1's MRI on 4/25/24.

During an interview on 11/12/24, at 9:53 a.m., Quality Specialist (QS) B stated RN E could not remember whether Patient 1's esophageal temp probe was communicated to him by the previous nurse.

During an interview on 11/13/24, at 10:45 a.m., the Executive Director Quality & Safety (EDQS) stated Patient 1's flowsheet contained documentation of an

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	esophageal probe and it is the nurse's responsibility to know and check for what items the patient has. Review of an email sent on 11/14/24, at 10:41 a.m., QS B indicated that there were no care plans prior to 4/25/24 specifically addressing esophageal probes. Review of the facility's policy, "Magnetic Resonance Imaging (MRI) Safety," last approved 7/2019 indicated, "Practices outline here are aligned with the 2017 American College of Radiology (ACR) Practice Parameters for Performing and Interpreting MRI and the 2013 ACR Guidance Document on MRI Safe Practices." The policy also indicated, "All patients entering Zone 4 [MRI scanner magnet room] will be thoroughly screened for non-MRI conditional apparatuses prior to entry ... " Review of "Appendix A; MRI Screening Procedure for Incapacitated Inpatients," of the facility's "MRI Safety" policy, indicated, "The MR safety screening form is the final safety checkpoint for patients undergoing an MRI exam ... The screening for will then be filled out with the nurse who will go through the questions ..." Review of the facility's policy, "Standards of Practice for Acute and Critical Care Nursing," approved 11/2021 indicated, "Through Assessment, the nurse collects data pertinent to the patient's condition or health status ... Documents relevant data in EHR [electronic health record] in a clear, timely manner ... The nurse caring for the patient develops a plan of care that prescribes strategies and alternatives to			

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	attain desired outcomes ... establishes priorities and continuity of care within the plan, including transfer of information and handoffs at shift change ... documents plan in the Care Plan system within the EHR and provides handoff of the plan in a clear, timely manner." Review of the "Appendix A: Critical Care Standard Work" from the policy, "Standards of Practice for Acute and Critical Care Nursing" indicated record temperature (and more frequently as needed) and document lines and tubes every four hours. The facility failed to identify and communicate the presence of Patient 1's esophageal temperature probe prior to an MRI. This failure resulted in Patient 1 suffering burn injuries to the lips, mouth, and tongue during the MRI. This failure resulted in a situation in which the facility's noncompliance with one or more requirements of licensure have caused, or was likely to cause, serious injury to Patient 1 and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code section 1280.3, subdivision (h). 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(h).			