

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/09/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/17/2008
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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562
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(A 000)	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during a follow-up survey conducted July 14 through July 17, 2008. The Southwest Healthcare System is comprised of two hospitals (Inland Valley Medical Center and Rancho Springs Medical Center) under the same licensure.</p> <p>Representing the Department: Deanne Martzolf, HFEN; Tina Buchanan, HFEN; Sheldeen Grimes, HFEN; Linda Bossolono, HFEN; Jennifer Hoke, RN, Nurse Consultant; Shola Ayodele, RD, Nutrition Consultant; Dongjoon Song, PharmD, Pharmacy Consultant; and Morton Kligerman, MD, Medical Consultant.</p> <p>The average daily census was 147</p> <p>The sample size was 112 patients. BiPAP-Bi-Level Positive Airway Pressure cc-Cubic Centimeter CCR-California Code of Regulations CDC - Center for Disease Control and Prevention CDPH-California Department of Public Health C-diff - Clostridium Difficile CN-Charge Nurse CNO-Chief Nursing Officer COO-Chief Operating Officer C/P-Care plan CRT - Certified Radiology Technician DFN-Director of Food and Nutrition DOP-Director of Pharmacy ED-Emergency Department GI - Gastrointestinal HD-Hemodialysis</p>	(A 000)	<p>By submitting this plan of correction, the Hospital does not agree that the citations are correct or that it violated the rules.</p>	<p>09 FEB 13 PM 1:31</p> <p>LICENSING & CERT. RIVERSIDE COUNTY</p> <p>CA DEPT OF PUBLIC HEALTH</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dennis Fox CEO</i>	TITLE CEO	(X6) DATE 2/10/09
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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. (See instructions.) Except for nursing homes, the findings stated 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.

Poc Accountable Per CMS 3/17/09 2457A (MD)

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{A 000}	Continued From page 1 HS-House Supervisor ICU - Intensive Care Unit IVMC - Inland Valley Medical Center L-Left LN-Licensed Nurse LS-Low Sodium MAR-Medication Administration Record MRSA - Methicillin Resistant Staph Aureus mcg/min-micrograms per minute NM-Nurse Manager NTG-Nitroglycerin OR - Operating Room O2-Oxygen PACU-Post Anesthesia Care Unit PCU-Progressive Care Unit PI-Performance Improvement POC-Plan of Correction PPM-Parts Per Million P & P- Policy and Procedure RCP-Respiratory Care Practitioner RD-Registered Dietician RN - Registered Nurse RMC - Rancho Springs Medical Center RTS - Radiology Technician Student SBP-Systolic Blood Pressure SPD - Sterile Processing Department SWHCS-Southwest Healthcare Systems UHS-Universal Health Services, Inc Tech - Technician	{A 000}		
{A 020}	482.11 COMPLIANCE WITH FEDERAL LAWS The hospital must ensure that specific Federal, State and local law requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the IVMC campus failed to ensure general	{A 020}	Please see detailed response under A 022 for corrective actions the Hospital has taken in response to these citations. The Hospital nevertheless disagrees with the citation's implication that it has refused to comply with the law. Please see rebuttal under A 022 for description of how the	09 FEB 13 PM 1:32 LICENSING & CERT RIVERSIDE COUNTY CA DEPT OF PUBLIC HEALTH

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{A 020}	Continued From page 2 acute care beds were not converted into ICU beds in accordance with California state law, CCR, Title 22, Division 5, §70805, resulting in the admission of one ICU patient (Patient 217) to the medical surgical floor for ICU care, and the potential for harm and death to the patient. This repeated failure to comply with the California state law continued after; a. being informed verbally of the deficient practice and the need to discontinue the practice during a federal validation survey completed October 5, 2007; b. being informed verbally of the continued deficient practice and the need to discontinue the practice during an unannounced visit to the facility on April 16, 2008, and; c. the issuance of a written cease and desist, prepared by the CDPH headquarters, due to the continued deficient practice identified during an unannounced visit to the facility on June 6, 2008. (A022) The cumulative effect of these systemic problems resulted in the failure of the facility to provide patient care services in accordance with State licensure laws.	{A 020}	Hospital has continually implemented changes throughout the survey process in accordance with its understanding of the law and feedback from the surveyors.		
{A 022}	482.11(b) LICENSURE OF HOSPITAL The hospital must be licensed; or approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals.	{A 022}	CORRECTIVE ACTION: As soon as the surveyors identified this issue during the survey and before the survey was over, the Chief Nursing Officer took immediate action to review and confirm that the following procedures were in effect:	07/14/08	

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[A 022]	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the IVMC campus failed to ensure general acute care beds were not converted into ICU beds in accordance with California state law, resulting in the admission of one ICU patient (Patient 217) to the medical surgical floor for ICU care, and the potential for harm and death to the patient.</p> <p>Findings:</p> <p>According to CCR, Title 22, Division 5, §70805, "spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of the department."</p> <p>The facility's IVMC campus license to operate was reviewed on July 15, 2008. The license, with an effective date of September 7, 2006, and an update in August 2007, indicated the facility was licensed for eight ICU beds and 104 unspecified general acute care beds. There was no written documentation the State of California had approved the conversion of general acute care beds for other uses.</p> <p>During a federal validation survey completed October 5, 2007, the practice of admitting ICU patients to general acute care beds for ICU care was again identified. The CNO was notified during the survey the practice of converting general acute care beds to ICU beds was not in compliance with CCR, Title 22, Division 5, §70805, and was a deficient practice. The CNO was notified the facility could no longer admit ICU patients to the medical surgical floor, as the beds were not licensed for ICU.</p>	[A 022]	<p>a) Patients requiring ICU level of care should be admitted to a licensed ICU bed.</p> <p>b) When there is no bed available in the ICU, the following actions are taken:</p> <p>1) A patient who presents to the Emergency Department and requires ICU level of care is held in the Emergency Department until an ICU bed is available.</p> <p>2) A postoperative patient requiring ICU level of care remains in the Post Anesthesia Care Unit (PACU) until an ICU bed becomes available.</p> <p>3) When the clinical condition of a patient on a Medical-Surgical Unit changes so that the patient requires ICU level of care, the patient is held on the Medical-Surgical Unit until an ICU bed becomes available.</p> <p>c) Staffing plan for patients requiring ICU level who are not physically located in the ICU is as follows:</p> <p>1) The Emergency Department and the PACU are considered critical care areas. An ICU nurse is obtained to care for the patient in either of these areas and is supported by the ED and PACU nursing staff.</p> <p>2) When a Medical-Surgical patient's condition changes and requires an ICU level of care, two ICU nurses are assigned to be physically present on the unit. The appropriate nurse to patient ratio related to the ICU level of care is maintained.</p>		

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(A 022)	<p>Continued From page 5</p> <p>hanging on the walls, and in plain sight of any nurse walking by, as well as at the central nurse's station, with an audible alarm system that all staff in the unit could hear.</p> <p>The IVMC ICU census sheets were reviewed on July 15, 2008. The sheets indicated Patient 217 was a patient in an ICU bed on July 12, 2008. The sheets indicated Patient 217 was moved to a medical surgical bed the night of July 12, 2008, still needing ICU care, to accommodate a neurosurgical patient.</p> <p>The record for Patient 217 was reviewed on July 15, 2008. Patient 217, a 73 year old female, was admitted to the facility ICU on July 4, 2008, with diagnoses that included respiratory failure. The patient was on a ventilator when admitted to the ICU. On July 11, 2008, the patient was weaned off the ventilator, and placed on a BiPAP machine (positive pressure machine to aid in effective breathing, requiring close and intensive monitoring). Patient 217 was transferred to the medical surgical floor, still requiring ICU care and a BiPAP machine</p> <p>The HS ICU tracking tool dated July 12, 2008, was reviewed on July 15, 2008. The tool indicated the HS was directed by the CNO to move Patient 217 out of the ICU to the medical surgical floor while Patient 217 still required ICU care.</p> <p>The HS who worked July 12, 2008, was interviewed July 15, 2008, at 4 p.m. The HS stated she was directed by the CNO to move Patient 217 out of ICU (although the patient still required ICU care) to accommodate a neurosurgical patient.</p>	(A 022)	<p>d) The Special Care Committee and the P&P Committee reviewed and approved Policies and Procedures for the PCU.</p> <p>e) Administration hired additional nursing staff members with appropriate training and competency to work in the PCU, and provided orientation to the new PCU.</p> <p>f) The Hospital opened the new PCU at the IVMC campus.</p> <p>MONITORING:</p> <p>a) The Director of Critical Care monitors the bed utilization in both the ICU and the PCU, and works with the attending physician and the ICU Medical Director to be sure patients are admitted to the appropriate level of care.</p> <p>b) Physicians or nurses may present concerns to the Director of Critical Care and/or bring them up in the PCU staff meetings for discussion and action planning, as appropriate.</p> <p>c) The Director of Critical Care reports to the Special Care Committee on trends and variances in the PCU.</p> <p>REBUTTAL:</p> <p>The Hospital respectfully disagrees with the citation's implication that the Hospital has been regularly and deliberately violating California law. The Hospital made initial changes to its practices in accordance with staff's understanding of the surveyors' comments during the full book survey that concluded on 10/02/07. The Hospital then</p>	08/26/08	09/01/08	09/08/08	09/08/08 & ongoing	09/08/08 & ongoing	09/08/08 & ongoing

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<p>{A 022}</p> <p>A 043</p>	<p>Continued From page 6</p> <p>During a tour of the medical surgical floor at the IVMC campus on July 15, 2008, at 4:15 p.m., the floor was observed to have one nursing station in the front of each wing, with long hallways that led to individual patient rooms. There was one medication room located on each wing, a supply room, and a dirty utility room. With the physical layout of the floor, a nurse caring for an ICU patient would have to travel down the hall for medications, supplies, assistance with order entry into the computer, and to find help, leaving the patient unattended and at risk for decompensation without immediate recognition.</p> <p>482.12 GOVERNING BODY</p> <p>The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.</p> <p>This CONDITION is not met as evidenced by: Based on observation, interview and record review, the governing body failed to:</p> <p>1) ensure the conduct of the IVMC campus was in accordance with (California state law) CCR, Title 22, Division 5, §70805, resulting in the admission of one ICU patient (Patient 217) to the medical surgical floor for ICU care, and the potential for harm and death to the patient;</p> <p>This repeated failure to comply with the California state law continued after;</p>	<p>{A 022}</p> <p>A 043</p>	<p>made subsequent changes following receipt of the 10/02/07 deficiency statement, which was not received until 03/29/08. The Hospital submitted its plan of correction to CMS on 04/18/08, two days after the unannounced site visit mentioned in the citation, and submitted additional revisions on 06/12/08. From 06/12/08 to the present, the Hospital has had only the one cited instance of moving an ICU patient from the ICU to the medical/surgical floor while the patient still met ICU criteria because the ICU beds were full and another patient with greater acuity needed an ICU bed.</p> <p>Because moving patient #217 was the only such instance since implementation of the Hospital's corrective action on 06/12/08, the Hospital submits that it was in substantial compliance with the rules at the time of the resurvey.</p> <p>The Board of Governors reviewed the information provided to the Hospital staff during the exit conference from the survey on 07/17/08. The CNO and CEO presented the issues identified during the exit conference on 07/17/08 to the Board of Governors and reported that leadership had identified a point person to address each finding identified by the survey team. The Board of Governors concurred with the plan.</p> <p>The Administrative Director, Quality Outcomes (ADQO) updated the Board of Governors on the status of improvements</p>	<p></p> <p>07/28/08</p> <p>09/15/08</p>
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A 043	Continued From page 7 a. being informed verbally of the deficient practice and the need to discontinue the practice during a federal validation survey completed October 5, 2007; b. being informed verbally of the continued deficient practice and the need to discontinue the practice during an unannounced visit to the facility on April 16, 2008, and; c. the issuance of a written cease and desist, prepared by the CDPH headquarters, due to the continued deficient practice identified during an unannounced visit to the facility on June 6, 2008 (A022); 2) ensure compliance with the facility policy regarding management of resources to accommodate ICU patients at the IVMC campus for eight of 15 patients admitted to PACU for ICU care (Patients 111, 112, 204, 205, 206, 207, 226, and 230), by failing to defer elective admissions requiring ICU care, resulting in post operative ICU care being provided in the PACU for these patients, and the potential for harm and death; 3) ensure the infection control program provided a safe and sanitary environment for patients, resulting in the potential for use of unsterilized instruments and the spread of infectious diseases during surgical procedures (A 748) (A 940), and; 4) ensure surgical services were provided in a safe and effective manner, to meet the needs of all patients, resulting in the potential for injury, and the spread of infectious diseases (A 940). The cumulative effect of these systemic problems resulted in the failure of the governing body to	A 043	made in response to issues identified by the surveyors during the survey and notified the Board that no official report had been received yet The ADQO provided the Board of Governors with a list of the deficiencies from the official CMS 2567 that had been received on 11/06/08, the individuals tasked with addressing each deficiency, and the plan for responding. The Board of Governors concurred with the assignments and plan for responding, and directed that an ongoing update be provided to the Board of Governors. 1. ICU PATIENTS: CORRECTIVE ACTION: As soon as the surveyors identified this issue during the survey and before the survey was over, the Chief Nursing Officer reviewed and confirmed that the following procedures were and are in effect: a) Patients requiring ICU level of care should be admitted to a licensed ICU bed. b) When there is no bed available in the ICU, the following actions are taken: 1) A patient who presents to the Emergency Department and requires ICU level of care is held in the Emergency Department until an ICU bed is available. 2) A postoperative patient requiring ICU level of care remains in the Post Anesthesia Care Unit (PACU) until an ICU bed becomes available. 3) When the clinical condition of a patient on a Medical-Surgical Unit changes so that the patient requires ICU level of care, the patient is	11/17/08 & ongoing	07/14/08

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A 043	<p>Continued From page 8</p> <p>operate both campuses of the facility in a manner that was safe and effective, and met the needs of the patients.</p> <p>Findings:</p> <p>1) According to CCR, Title 22, Division 5, §70805, "spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of the department."</p> <p>The facility's IVMC campus license to operate was reviewed on July 15, 2008. The license, with an effective date of September 7, 2006, and an update in August, 2007, indicated the facility was licensed for eight ICU beds and 104 unspecified general acute care beds. There was no written documentation the State of California had approved the conversion of any of the general acute care beds for other uses.</p> <p>During a federal validation survey completed October 5, 2007, the practice of admitting ICU patients to general acute care beds for ICU care was identified. The CNO was notified during the survey the practice of converting general acute care beds to ICU beds was not in compliance with CCR, Title 22, Division 5, §70805, and was a deficient practice. The CNO was notified the facility could no longer admit ICU patients to the medical surgical floor, as the beds were not licensed for ICU.</p> <p>During an unannounced visit to the IVMC campus on April 16, 2008, the practice of admitting ICU patients to general acute care beds for ICU care was again identified. The CNO and Director of ICU/ED were notified on April 16, 2008, at 3:05</p>	A 043	<p>held on the Medical-Surgical Unit until an ICU bed becomes available.</p> <p>c) Staffing plan for patients requiring ICU level who are not physically located in the ICU is as follows:</p> <p>1) The Emergency Department and the PACU are considered critical care areas. An ICU nurse is obtained to care for the patient in either of these areas and is supported by the ED and PACU nursing staff.</p> <p>2) When a Medical-Surgical patient's condition changes and requires an ICU level of care, two ICU nurses are assigned to be physically present on the unit. The appropriate nurse to patient ratio related to the ICU level of care is maintained.</p> <p>The CNO reported the ICU issues mentioned by the surveyors at the exit conference to the Board of Governors, which confirmed the plan for the CNO and others on the leadership team to address those concerns.</p> <p>After the conclusion of the survey, the Hospital took the following actions to address the need for critical care services at the IVMC campus:</p> <p>a) The Director of Critical Care convened a multi-disciplinary planning meeting for opening a PCU at the IVMC campus. The multi-disciplinary team reviewed an analysis that had been conducted by the Director of Critical Care and the ICU Medical Director, who had analyzed the types of patients admitted to the ICU and determined that many patients in the ICU who did not meet criteria to be moved to a medical/surgical unit nevertheless met the criteria for admission to a Progressive Care Unit (PCU), which specializes "in the immediate care of all medically guarded patients with single and multiple systems failure. Patients</p>	07/28/08	07/25/08

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A 043	<p>Continued From page 9</p> <p>p.m., the practice of converting general acute care beds to ICU beds was not in compliance with CCR, Title 22, Division 5, §70805, and was a deficient practice. Both were notified they could no longer admit ICU patients to the medical surgical floor, as the beds were not licensed for ICU.</p> <p>During an unannounced visit to the IVMC campus on June 6, 2008, the practice of admitting ICU patients to general acute care beds for ICU care was again identified. A written cease and desist, prepared by the CDPH headquarters, was issued to the COO on June 6, 2008, at 9:35 a.m. The cease and desist was issued due to the facility's repeated failure to stop conversion of general acute care beds to ICU beds.</p> <p>The facility POC from the federal survey completed October 5, 2007, was reviewed on July 14, 2008. The POC indicated, "Patients requiring ICU level of care must be admitted only to a licensed ICU bed," and ICU patients would not be admitted to beds licensed for any other purpose. The completion date for the POC was June 6, 2008.</p> <p>During a tour of the ICU at the IVMC campus on July 15, 2008, at 1:37 p.m., the unit was observed to be oval in shape, with each bed visible from the nurses station. The patient beds were in close proximity to a nurse at the station, or at any location in the unit. The cardiac monitors were hanging on the walls, and in plain sight of any nurse walking by, as well as at the central nurse's station, with an audible alarm system that all staff in the unit could hear.</p> <p>The IVMC ICU census sheets were reviewed on</p>	A 043	<p>include those experiencing cardiac disease, pulmonary, renal, neurological, neurovascular and orthopedic problems, including post surgical patients who require advanced medical and nursing or respiratory care. Close observation, telemetry monitoring and advanced technological services are offered per policy and procedure." A PCU is comprised of beds licensed as general acute care beds with a higher nurse:patient ratio than is used for medical/surgical patients.</p> <p>b) The CEO, CNO, Chief of Staff, and the ICU Medical Director circulated a letter of information to the Medical Staff regarding the PCU at the IVMC campus.</p> <p>c) Nursing Administration and Materials Management staff met to review all supply issues.</p> <p>d) The Special Care Committee and the P&P Committee reviewed and approved Policies and Procedures for the PCU.</p> <p>e) Administration hired additional nursing staff members with appropriate training and competency to work in the PCU, and provided orientation to the new PCU.</p> <p>f) The Hospital opened the new PCU at the IVMC campus.</p> <p>g) The CEO updated the Board of Governors on the opening of the new PCU.</p> <p>h) The ADQO provided a followup report to the Board of Governors following receipt of the official CMS 2567.</p>	08/04/08 08/07/08 08/26/08 09/01/08 09/08/08 09/15/08 11/17/08

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/17/2008
NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM			STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562		
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A 043	<p>Continued From page 10</p> <p>July 15, 2008. The sheets indicated Patient 217 was a patient in an ICU bed on July 12, 2008. The sheets indicated Patient 217 was moved to a medical surgical bed the night of July 12, 2008, still needing ICU care, to accommodate a neurosurgical patient.</p> <p>The record for Patient 217 was reviewed on July 15, 2008. Patient 217, a 73 year old female, was admitted to the facility ICU on July 4, 2008, with diagnoses that included respiratory failure. The patient was on a ventilator when admitted to the ICU. On July 11, 2008, the patient was weaned off the ventilator, and placed on a BiPAP machine (positive pressure machine to aid in effective breathing, requiring close and intensive monitoring). Patient 217 was transferred to the medical surgical floor, still requiring ICU care and a Bipap machine</p> <p>The HS ICU tracking tool dated July 12, 2008, was reviewed on July 15, 2008. The tool indicated the HS was directed by the CNO to move Patient 217 out of the ICU to the medical surgical floor while Patient 217 still required ICU care.</p> <p>The HS who worked July 12, 2008, was interviewed July 15, 2008, at 4 p.m. The HS stated she was directed by the CNO to move Patient 217 out of ICU (although the patient still required ICU care) to accommodate a neurosurgical patient.</p> <p>During a tour of the medical surgical unit at the IVMC campus on July 15, 2008, at 4:15 p.m., the unit was observed to have one nursing station in the front of each wing, with long hallways that led to individual patient rooms. There was one</p>	A 043	<p>MONITORING:</p> <p>a) The Director of Critical Care monitors the bed utilization in both the ICU and the PCU, and works with the attending physician and the ICU Medical Director to be sure patients are admitted to the appropriate level of care.</p> <p>b) Physicians or nurses may present concerns to the Director of Critical Care and/or bring them up in the PCU staff meetings for discussion and action planning as appropriate.</p> <p>c) The Director of Critical Care reports to the Special Care Committee on trends and variances in the PCU. The Special Care Committee reports trends and variances in the PCU, as appropriate, to the Board of Governors bimonthly.</p> <p>REBUTTAL:</p> <p>The Hospital respectfully disagrees with the citation's implication that the Hospital has been regularly and deliberately violating California law. The Hospital made initial changes to its practices in accordance with staff's understanding of the surveyors' comments during the full book survey that concluded on 10/02/07. The Hospital then made subsequent changes following receipt of the 10/02/07 deficiency statement, which was not received until 03/29/08. The Hospital submitted its plan of correction to CMS on 04/18/08, two days after the unannounced site visit mentioned in the citation, and submitted additional revisions on 06/12/08. From 06/12/08 to the present, the Hospital has had only the one cited instance of moving an ICU patient from the ICU to the medical/surgical floor while the patient still met ICU criteria because the ICU beds were full and another patient with greater acuity needed an ICU bed.</p>	09/08/08 & ongoing 09/08/08 & ongoing 09/08/08 & ongoing	

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A 043	Continued From page 12 The ICU census sheets were reviewed on July 16, 2008. The sheet dated June 24, 2008, indicated the ICU beds were full, with one patient on the medical surgical unit waiting for an ICU bed, and one patient in the PACU waiting for an ICU bed when Patient 112 was taken to surgery. The census sheets further indicated Patient 112 stayed in the PACU for 1.5 days requiring ICU care. Records indicated Patient 112 was never admitted into an ICU bed during the patient's length of stay. c) The record for Patient 204 was reviewed on July 16, 2008. The record indicated Patient 204, an 82 year old female, was admitted to the facility pre operative unit on June 9, 2008, for an elective carotid endarterectomy (opening the carotid artery to remove plaque). The post operative orders indicated the patient was to be admitted to the ICU. The ICU census sheets were reviewed on July 16, 2008. The sheet dated June 9, 2008, indicated the ICU beds were full, with three patients in the ED waiting for ICU beds, and two patients in the PACU waiting for ICU beds when Patient 204 was taken to surgery. The census sheets further indicated Patient 204 stayed in the PACU for 1.5 days requiring ICU care, and was transferred to the medical surgical unit. Patient 204 was not admitted to an ICU bed during the patient's entire length of stay. d) The record for Patient 205 was reviewed on July 16, 2008. The record indicated Patient 205, a 66 year old female, was admitted to the facility pre operative unit on June 9, 2008, for an elective carotid endarterectomy (opening the carotid	A 043	ability to admit a post-operative patient to the ICU, particularly because not all morning surgical admissions are truly "elective," the CNO or designee contacts the surgeon to discuss the situation. 3) The surgeon, once provided the information regarding Hospital resources, then considers the medical/surgical needs of the patient to determine if the benefit of proceeding with the planned procedure outweighs the potential risk that there may not be a designated ICU bed immediately available for the patient and that the patient may be cared for (by an ICU competent nurse) beyond the normal recovery time in the PACU. 4) Based upon this evaluation, the surgical case is delayed, rescheduled, or performed as scheduled. 5) Should the decision be to proceed with the scheduled procedure at the scheduled time, the CNO/designee makes sure to assign appropriate nursing staff to meet the care needs of the patient and comply with the California rules. c) The CNO and CEO reported to the Board of Governors the summary of findings from the exit conference and the plan for responding. The Board of Governors confirmed the plan. d) The ADQO provided followup reports to the Board of Governors on this issue, providing more detail at the 11/17/08 meeting. MONITORING: a) On a daily basis, the House Supervisors track ICU patients. Should there be patients outside of the ICU who are awaiting an ICU bed, the House Supervisors complete a	07/28/08 09/15/08 & 11/17/08 07/17/08 & ongoing	

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A 043	Continued From page 14 elective spinal fusion. The post operative orders indicated the patient was to be admitted to the ICU. The ICU census sheets were reviewed on July 16, 2008. The sheet dated June 16, 2008, indicated the ICU beds were full when Patient 207 was taken to surgery. The census sheets further indicated Patient 207 stayed in the PACU for 24 hours requiring ICU care, and was transferred to the medical surgical unit. Patient 207 was not admitted to an ICU bed during the patient's entire length of stay. g) The record for Patient 226 was reviewed on July 16, 2008. The record indicated Patient 226, a 69 year old female, was admitted to the facility pre operative unit on June 18, 2008, for an elective carotid endarterectomy. The Short Stay History and Physical dated June 18, 2008 at 10 a.m., indicated Patient 226 was admitted with a chief complaint of "TIA (Transient Ischemic Attack) April 2008 Slurred speech." The plan of care indicated the patient was to undergo "L CEA," (Left Carotid endarterectomy). Carotid endarterectomy is a surgical procedure in which plaque is removed from a carotid artery. Post surgical risks include neurological complications, secondary to stroke and potentially life-threatening swelling of the neck due to hemorrhage. The patient's pre operative assessment indicated the patient was brought to the facility by a spouse at 8 a.m., on June 18, 2008. The operative report indicated the patient underwent carotid endarterectomy, with patch angioplasty on June 18, 2008. The post operative orders indicated the	A 043	c. Following the conclusion of the survey, the Directors of Infection Control and Perioperative Services reviewed the Hospital policy, "Cleaning and Sterilizing Equipment and Supplies" in light of the most current recommendations and guidelines of the Association of periOperative Registered Nurses (AORN) and the Association for the Advancement of Medical Instrumentation (AAMI) as they relate to the proper cleaning of instruments, and added a clarifying statement to read, "Instruments not grossly soiled will be individually unlocked and inspected for dirt, soil, bioburden, or any foreign material prior to being placed in the ultrasonic and/or washer disinfectant." The Directors also verified that the policy directed that employees are to follow the manufacturer's guidelines when using cleaning agents. The P&P Committee approved the revision to the policy. d. The Directors reviewed the policy with the Perioperative Leadership team to assure that all had a clear understanding of the policy and of the expectations that the Leads provide oversight by monitoring all SPD Techs, validating on an ongoing basis that the cleaning process is consistent with Hospital policy. e. The ICD re-educated the SPD Tech who had been removed from duty. The education included a review of hospital policy concerning cleaning and sterilizing equipment and supplies, proper cleaning of all instruments on the tray, use of solvent and use of the pressurized air hose when cleaning tubing. The SPD tech completed a competency evaluation to confirm understanding of all requirements prior to resuming duties. f. The CNO and CEO reported the preliminary findings from the exit conference to the Board of Governors.	07/22/08	07/22/08	07/25/08	07/28/08

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A 043	Continued From page 15 patient was to be admitted to the ICU. The operative report indicated Patient 226's disposition was the recovery room, then ICU. On June 18, 2008, at 1:45 p.m., it was documented in the nurse's notes the patient was "ICU hold in PACU." On July 16, 2008, the Critical Care Unit (ICU) census report for June 18, 2008, was reviewed. The report indicated the facility had eight patients in the intensive Care Unit and an additional four patients in the emergency room waiting for ICU beds, when Patient 226 was admitted for surgery. The census sheets further indicated Patient 226 remained in the PACU for two days, requiring ICU care, until June 20, 2008, when she was discharged home. Patient 226 was not admitted to an ICU bed during the patient's entire length of stay. h) The clinical record for Patient 230 was reviewed on July 16, 2008. The record indicated Patient 230, a 63 year old male, was admitted to the facility pre operative unit on June 26, 2008, for an elective abdominal aneurysm (a weakness in the wall of the artery) repair. Post operatively, the patient had an arterial line and required ICU placement. On July 16, 2008, the Critical Care Unit (ICU) census report for June 26, 2008, was reviewed. The report indicated the facility had eight patients in the Intensive Care Unit and two additional patients in the emergency room waiting for ICU beds, when Patient 230 was admitted for surgery. Patient 230 was transferred to the ICU after 24 hours in the PACU.	A 043	g. Once the SPD Tech successfully completed the competency evaluation, the ICD/designee monitored the SPD Tech via job shadowing with concurrent observation for one week, to be sure that the SPD Tech was complying with Hospital policy for the proper cleaning of instruments. h. The SPD Leads directly observed all techs to confirm that each employee followed Hospital policy and that all steps in the instrument cleaning process were completed properly, and the staff were using a measuring cup when preparing the GI scope cleaning solutions. i. The ADQO provided a followup report to the Board of Governors. j. The ICD reviewed Information related to the findings of the July survey and provided ongoing updates at Perioperative Board Rounds and Staff Meetings. k. The ADQO provided more detailed reports to the Board of Governors following receipt of the official CMS 2567, and the Board of Governors concurred with the plan for responding and directed that an ongoing update on these issues be provided at future Board meetings. MONITORING: a. The SPD Lead and the ICD conducted real-time observations over the next month to validate that all SPD policies were being followed when instruments and other supplies were cleaned and processed. b. The SPD Lead and the ICD continue to monitor compliance through random real-time monitoring of SPD Techs while they perform cleaning processes. The ICD reports results/variances from this monitoring quarterly	08/01/08 08/04/08 09/15/08 09/30/08 11/17/08 08/29/08 09/01/08 & ongoing	

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{A 043}	Continuation Page--	{A 043}	<p>f. The ICD also took the information regarding Caviwipes to the Chair of the Infection Control Committee, an Infectious Disease specialist, for final approval.</p> <p>g. The ICD provided the ordering information for Caviwipes to the Director of Materials Management. The ICD worked with the Director of Education to plan staff inservices on the product.</p> <p>h. The Director of Education disseminated the staff education material. The vendor of the product was also on site to assist with staff education.</p> <p>i. The Caviwipe product was received and implemented.</p> <p>MONITORING:</p> <p>a. During the interim while the ICD was investigating possible replacement products, during Infection Control EVS routine rounding, members of Leadership directly observed staff using the Sanicloths to assure that they were following proper disinfection time.</p> <p>b. Unit-based leaders and Infection Control staff directly observe staff use of the Caviwipe to assure that staff are allowing the 3-minute surface disinfection time. Ongoing "on-the-spot" feedback is being provided to assure compliance with the product's manufacturer's guidelines.</p> <p>c. The ICD reports results/variances from this monitoring quarterly to the Infection Control Committee, which initiates performance improvement action planning and reports as appropriate to the MEC.</p> <p>d. Trends and variances, as indicated, are reported to the Board of Governors at its bimonthly meeting by either the MEC or the ADQO.</p>	<p>11/17/08</p> <p>11/17/08</p> <p>12/03/08</p> <p>12/05/08</p> <p>07/21/08 through 12/05/08</p> <p>12/06/08 & ongoing</p> <p>12/06/08 & ongoing</p> <p>12/06/08 & ongoing</p>	

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{A 043}	Continuation Page--	{A 043}	<p>(3) VISITORS & ISOLATION PRECAUTIONS:</p> <p>CORRECTIVE ACTION:</p> <p>To assure that visitors are educated regarding isolation practices and that the patient's care plan is up-to-date with appropriate entries related to isolation, the Hospital took the following actions:</p> <ul style="list-style-type: none"> a. Immediately after the surveyors identified this issue and before the survey was over, the ICD spoke with the nurses caring for the identified patients to review this important aspect of care and the expectations as identified by hospital policy "Isolation Precautions". The visitors were provided with pertinent information relating to isolation practices, and the care plans were updated. b. Immediately after the survey, the ICD attended the hospital-wide Charge Nurses' Meeting to review the survey findings and discuss and reiterate the expectations as outlined in hospital policy relating to isolation practices that require visitor education and documentation in the patient's care plan and education record. c. The CNO and CEO reported the findings from the exit conference to the Board of Governors. d. The Nursing Managers discussed these issues with staff during unit rounds to assure that all nurses understood the expectations with respect to documenting precautions in care plans and educating families and visitors on isolation precautions. e. The ADQO provided followup reports on this issue to the Board of Governors. 	<p>07/17/08</p> <p>07/18/08</p> <p>07/28/08</p> <p>08/31/08</p> <p>09/15/08 & 11/17/08</p>

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{A 043}	Continuation Page--	{A 043}	<p>MONITORING:</p> <p>a. Infection Control staff conduct regular rounds on all patients in isolation. Incorporated into the rounding process is a review of the patient's chart for completeness of documentation (care plan and education forms). In addition, if there are visitors present during rounds, the Infection Control staff interview the visitors to confirm that they have been provided education relating to the patient's isolation status and the necessary precautions that apply.</p> <p>b. During the IC rounds, should the Infection Control staff identify any concerns, the IC staff give "on-the-spot" feedback, education, and clarification as appropriate. The IC staff provide feedback to the unit manager as appropriate.</p> <p>c. The ICD reports results/variances from this monitoring quarterly to the Infection Control Committee, which initiates performance improvement action planning and reports to the MEC as appropriate.</p> <p>d. The Board of Governors receives bimonthly reports on Infection Control issues, as indicated, from the MEC or the ADQO.</p> <p>(4.a.) SUB STERILE ROOM:</p> <p>CORRECTIVE ACTION:</p> <p>To assure that the Hospital maintains an environment that prevents the source and spread of infection, the following actions were taken to address the findings in the sub-sterile room at the Inland Valley campus:</p> <p>a. Immediately after the survey, the ICD and Director of Perioperative Services inspected the sub sterile room with the Plant Operations Manager. They confirmed that the IV solutions were sealed and in an enclosed cabinet; the blanket warmer had an adequate seal due to the</p>	08/01/08 & ongoing 08/01/08 & ongoing 08/01/08 & ongoing 08/01/08 & ongoing	
				07/18/08	

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{A 043}	Continuation Page--	{A 043}	<p>door seal protecting the contents; the open storage rack in the alcove contained only supplies that are impervious to moisture and unaffected should there be temperature changes associated when the door of the sterilizer is opened; and the door to the sterilizer opened out and away from the storage alcove to better disperse the steam.</p> <p>b. The Plant Operations staff removed the dirty towels surrounding the drain and thoroughly cleaned the area. The ICD then inspected the area for cleanliness and instructed staff members not to place any material, such as towels, about the drain.</p> <p>c. The Plant Operations staff checked the functioning of the drain to confirm that there were no restrictions that might prevent adequate draining of water from the normal functioning of the sterilizer. They determined that the drain functioned appropriately, but recommended that the drain be replaced prior to the end of the year to prevent any future problems.</p> <p>d. The CNO and CEO reported the survey findings from the exit conference to the Board of Governors.</p> <p>e. Staff reviewed and discussed information related to the findings of the July survey at the Perioperative staff meetings.</p> <p>f. The ADQO reported the status of corrective action to the Board of Governors, along with more detail about the findings and individuals tasked with correction and response.</p> <p>g. The Plant Operations staff had the floor drain in the sub sterile room replaced.</p>	<p>07/18/08</p> <p>07/18/08</p> <p>07/28/08</p> <p>08/21/08</p> <p>09/15/08 & 11/17/08</p> <p>11/30/08</p>

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{A 043}	Continuation Page--	{A 043}	<p>MONITORING:</p> <p>a. The OR Charge Nurse checks the sub sterile room daily and reports any identified concerns to Plant Operations for immediate correction.</p> <p>b. The ICD and the Plant Operations Manager also inspect the sub sterile room during normal monthly rounding.</p> <p>c. The ICD reports results/variances from this monitoring quarterly to the Infection Control Committee, which initiates performance improvement action planning and reports to the MEC as appropriate.</p> <p>d. The Board of Governors receives infection control reports bimonthly, as indicated, from either the MEC or the ADQO.</p> <p>(4.b) TORN ARMREST:</p> <p>CORRECTIVE ACTION:</p> <p>To assure that the Hospital maintains an environment that prevents the source and spread of infection, the following actions were taken:</p> <p>a. As soon as the surveyors identified the torn armrest during the survey, the Director of Perioperative Services immediately had the armrest with the partial tear removed from service and replaced with an armrest with a fully intact covering.</p> <p>b. To prevent a recurrence, the Director of Perioperative Services implemented the following process:</p> <p>(1) In the morning, prior to the first case, the circulator inspects each OR to confirm that all pad coverings are intact and without tears.</p>	07/21/08 & ongoing 07/21/08 & ongoing 07/21/08 & ongoing 07/21/08 & ongoing 07/14/08 07/18/08	

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{A 043}	Continuation Page--	{A 043}	<p>(2) At the conclusion of each case, as the room is cleaned, the EVS staff member again visually inspects all pads for integrity. Should any pad have a tear, the EVS staff member notifies the Circulator, who is responsible for having the pad replaced prior to setting up for the next case.</p> <p>c. The CNO and CEO reported the survey findings from the exit conference to the Board of Governors.</p> <p>d. The staff member who orders supplies routinely checks the number of armrests to be sure there are two sets in stock.</p> <p>e. Information related to the findings of the July survey was reviewed and discussed at the Perioperative Board Rounds and Staff Meetings.</p> <p>f. The ADQO provided followup reports to the Board of Governors on the findings from the survey and the status of corrective action.</p> <p>MONITORING:</p> <p>a. The OR Managers and Charge RNs are responsible for overseeing the ongoing check of the integrity of the OR table pad and for making concurrent observations to assure that the OR table pads have no tears that impair their integrity.</p> <p>b. The ICD also inspects the integrity of the OR table pads during routine rounds.</p> <p>c. The ICD reports results/variances from this monitoring quarterly to the Infection Control Committee, which initiates performance improvement action planning and reporting to the MEC as appropriate.</p> <p>d. Reports on infection control issues are provided bimonthly, as indicated, to the Board of Governors by either the MEC or the ADQO.</p>	07/28/08	08/01/08 & ongoing
				08/22/08	09/15/08 & 11/17/08
				08/01/08 & ongoing	08/01/08 & ongoing
				08/01/08 & ongoing	09/15/08 & ongoing

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{A 043}	Continuation Page--	{A 043}	(5) CLOSTRIDIUM DIFFICILE (C-DIFF): CORRECTIVE ACTION: a. The ICD and EVS Manager reviewed the CDC information on surface disinfectants. b. The ICD reviewed the policy on isolation precautions and confirmed that the information was consistent with current CDC recommendations for Contact Isolation. The ICD confirmed specifically that: (1) Hand hygiene is done exclusively by washing with soap and water; (2) Barrier protection is used (gowns, gloves); and (3) Daily room cleaning is done with an EPA-registered disinfectant. c. The ICD met with the EVS Manager to discuss terminal cleaning of isolation rooms and instructed the EVS Manager that when terminal cleaning of a patient room for C-Diff. is performed, the curtains are removed and all surfaces (including walls, floors, counters, etc.) are cleaned with a 1:10 solution of hypchlorite (bleach)/water. d. The CNO and CEO presented findings from the exit conference to the Board of Governors. e. The ADQO provided updates to the Board of Governors on survey findings and corrective action. f. The ICD and EVS Manager provided education to the EVS staff on the use of dilute bleach solution for terminal cleaning of C-Diff. isolation rooms informally during morning report meetings in July 2008 and formally at the EVS staff meetings in August and September 2008.	07/18/08	07/18/08
				07/18/08	07/18/08
				07/28/08	07/28/08
				09/15/08 & 11/17/08	09/15/08 & 11/17/08
				09/30/08	09/30/08

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{A 043}	Continuation Page--	{A 043}	<p>REBUTTAL:</p> <p>The Hospital respectfully submits that it was in compliance with Medicare rules with regard to C-Diff. The ICD and EVS Manager reviewed and confirmed that the Hospital has an effective program for preventing and limiting the spread of C-Diff in accordance with current recommendations of the CDC based on the following information:</p> <p>a. Reports indicate that C-Diff is on the rise nationally, but at the Rancho and Inland Valley campuses, the rate of hospital-acquired infection (HAI) with C-Diff is low and has been reduced further from 2007 to 2008. The Hospital HAI rate includes patients who developed C-Diff as a result of antibiotic therapy:</p> <p>2007:</p> <p> --Overall C-Diff rate: 1.42/1000 patient days --HAI Rate: 0.52/1000 patient days.</p> <p>Through 3rd Quarter 2008:</p> <p> --Overall C-Diff Rate: 1.55/1000 patient days --HAI Rate: 0.27/1000 patient days, a 48% reduction from the previous year</p> <p>b. The ICD and EVS Manager confirmed that CDC notes that there are NO EPA-registered surface disinfectants with label claims for the inactivation of C-Diff spores. The CDC has reviewed some limited research studies that seem to indicate use of a hypochlorite-based germicide may lower incidence of C-Diff and noted this information on page 85 in its "Guidelines for Environmental Infection Control in Health-Care Facilities." In the CDC "Guidelines for Disinfection and Sterilization of Healthcare Facilities, 2008," the CDC states:</p> <p> --"Because no EPA-registered products exist that are specific for inactivating C. difficile</p>	

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A 043	Continued From page 16 During a concurrent interview with the PACU CN and the PACU Lead, on July 16, 2008, at 11:50 a.m., both nurses stated the patients undergoing vascular surgery and spinal fusions routinely require admission to the ICU post operatively. The nurses stated they did not know if the patients would get an ICU bed postoperatively when the surgeries started, but they did not delay the surgeries to find out. The nurses stated the facility did not have a policy requiring them to check for the availability of an ICU bed before starting a surgery that would require an ICU bed postoperatively. During an interview with the vascular surgeon on July 16, 2008, at 12:30 p.m., the surgeon stated it was common for his patients not to get an ICU bed postoperatively, and to stay in the PACU for their entire ICU length of stay. The surgeon stated the situation was "not ideal," but he did not think he had a choice. The surgeon stated all of his patients having vascular surgical procedures required ICU care postoperatively, and the facility was aware of this.	A 043	spores, use of diluted hypochlorite SHOULD BE CONSIDERED in units with high C. difficile rates." (emphasis added) --"However, studies have shown that asymptomatic patients constitute an important reservoir within the health-care facility and that person-to-person transmission is the principal means of transmission between patients. Thus, combined use of hand washing, barrier protection, and meticulous environmental cleaning with an EPA-registered disinfectant should effectively prevent spread of the organism." The CDC further states in its information for Healthcare Providers, "Hospital cleaning products can be used for routine cleaning. Hypochlorite-based disinfectants have been used with some success for environmental surface disinfection in those patient-care areas where surveillance and epidemiology indicate ongoing transmission of C. difficile." Because the Hospital's rates of hospital-acquired C-Diff are actually decreasing, and because the program for cleaning was already consistent with CDC guidelines, the Hospital disagrees that it violated the Medicare rules.		
A 130	482.13(b)(1) PATIENT RIGHTS: PARTICIPATION IN CARE PLANNING The patient has the right to participate in the development and implementation of his or her plan of care. This STANDARD is not met as evidenced by: Based on observation, staff interview and review	A 130	In order for patients on a pureed diet to have the opportunity to participate in the nutritional plan of care related to food choices, the hospital took the following actions: CORRECTIVE ACTIONS: 1. Using the information provided in the Diet Manual approved by the P&T Committee on 10/24/2007, the Director of Food and Nutrition (DFN) developed new puree menus to provide variety so the patients can select their food	07/17/08	

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A 130	<p>Continued From page 17</p> <p>of menus and hospital policy and procedures, the hospital failed to provide two of two patients on pureed diets with selectable menus for food choices. This failure resulted in the denial of rights of the patients' or their legal representative's to select their food choices and therefore participate in the medical nutrition therapy.</p> <p>Finding:</p> <p>During trayline observation on July 14, 2008, at approximately 12:10 p.m., the trays for two patients were observed to have items other than what was listed on the menu. Both patients were on the pureed diet. The pureed menu for lunch contained the following entrees: Pureed beef burgundy, vegetable medley, strained cream of wheat, among other items. Both patients received preformed beef, green beans and mashed potato with gravy.</p> <p>During an interview with the DFN on July 14, 2008, at approximately 12:35 p.m., the failure of the food service staff to serve what was on the menu for both patients, was discussed. She stated the items observed on the trays were correct because patients on puree diets do not receive select menus. The menus observed were only used as place holders for the patients and that it was normally a blank piece of paper with the diet stamped on. She further explained that patients on pureed diets do not get to select their food. They are provided items that have been preselected for them.</p> <p>The diet clerk who distributed the menu around the hospital was interviewed on July 15, 2008, at approximately 11:40 a.m. She explained how she</p>	A 130	<p>choices in the usual menu categories. The menus themselves vary and are not the same on a day-to-day basis.</p> <p>2. Dietary staff round on patients with a puree diet to interview them relating to their food preferences. Patient requests for the onsite preparation of puree foods (hospital provided) are honored when they are consistent with the patient's prescribed diet and the requested item can be prepared in a timely manner.</p> <p>3. During the pre-formed puree product ordering process, the DFN reviews new product options as appropriate for inclusion as additional items for the puree menu.</p> <p>4. After reviewing the citations on the official CMS 2567, which was received on 11/06/08, the DFN took additional action by reviewing and revising the Dietary Policy #D2, "Diet Office Procedures" to incorporate the changes related to the puree menu. The policy was approved by the Policy & Procedure Committee. The DFN educated dietary staff on the revised policy.</p> <p>MONITORING:</p> <p>1. Tray checks:</p> <p>a) The dietitian or the lead diet clerk performs tray checks to assure adequacy and variety for all patients with a puree diet order.</p> <p>b) The dietitian addresses a staff member's concern regarding the content of the tray so it is resolved before the tray leaves the kitchen.</p> <p>c) The DFN provides feedback on the overall findings of tray line checks to the dietary staff at the unit-based staff meetings.</p>	<p>07/17/08</p> <p>07/17/08 & ongoing</p> <p>11/25/08</p> <p>07/17/08 & ongoing</p>
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A 130	Continued From page 18 distributed the menus and would ask some of the patients their food choices when they needed assistance. There was no rationale or explanation given for why some patients in the hospital received and made food selections while those on pureed diets were denied the opportunity. Lunch observation on July 15, 2008, revealed that patients on pureed diets received pureed beef, green beans and mashed potato with gravy. Through interview and this observation, it was later determined that patients on puree diets received the same meat (beef or chicken) the same meal everyday. For example, the same preformed pureed beef was served every day at lunch; same preformed chicken was served for dinner. There was no variety or change in flavor. (Cross refer A 628) The hospital P & P titled "Diet Office Procedures," was reviewed on July 14, 2008. The purpose of the P & P was stated as "The Dietary Department provides appropriate menus for physician ordered diets." The policy listed various diets served in the hospital, but the pureed diet was not listed. The absence of pureed diets from menu distribution, was not addressed. The hospital failed to ensure that the rights of patients to determine food choices were promoted.	A 130	d) The DFN added tray line checks to the department's QC Report beginning 3rd quarter 2008; these reports also go to the Operational PI Committee. 2. To facilitate the patient's participation in the nutritional plan of care: a) The diet clerk seeks patient input during the 1:1 interviews that occur during the menu selection process. b) The dietitian when rounding also seeks patient input. c) In addition, the DFN coordinates a patient satisfaction survey informally, using a hospital tool. d) An outside contractor also assesses patient satisfaction with dietary services as part of the hospital-wide patient satisfaction survey. e) The DFN or Food Service Manager presents the results of these surveys at the unit-based staff meetings and is responsible to take action to address identified opportunities for improvement.	08/01/08 & ongoing
{A 394}	482.23(b)(2) LICENSURE OF NURSING STAFF The nursing service must have a procedure in place to ensure that hospital nursing personnel for whom current licensure is required have a valid and current licensure.	{A 394}	CORRECTIVE ACTION: The Director of Nursing (DON) met with the Director of Resource Management to clarify expectations. Until a determination was made by the Chief Nursing Executive (CNE) and Director of Human Resources (DHR) on whether the license verification process could be revised, the HS continued to perform the	07/17/08

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{A 394}	<p>Continued From page 20</p> <p>The nurse must sign in and out in the book. The House Supervisor must check their license and obtain an online verification of their license. The House Supervisor must check the book for current competencies for that nurse. The House Supervisor must obtain an evaluation by the staff nurse or the charge nurse."</p> <p>The memo's instructions mirrored the facility's plan of correction with a completion date of April 2, 2008, submitted to the CDPH on June 12, 2008. The plan of correction indicated the Director of Resource Management established a new process that addressed "tracking/signing in of contracted staff, maintenance and verification of licensure, certification and competencies."</p> <p>The dialysis nurse sign-in sheet indicated HD RN 1 signed in on July 7, and 14, 2008. The tabbed section for HD RN 1 was reviewed. There was no on-line verification for July 7, 2008, for HD RN 1.</p> <p>During an interview with HS 2, on July 14, 2008, at 11:45 a.m., she stated HD RN 1 may have signed in while she was out of the office on July 7, 2008. HS 2 stated the staffing office was open and the HD RN was able to obtain the keys without her presence, as other staff was available. The HS stated the HD RN should have notified her that he was there to perform dialysis.</p> <p>On July 14, 2008, at 1145 a.m., the dialysis nurses' sign in sheets and online verification forms for RSMC were reviewed with the House Supervisor and the Director of Acute Medical Services. The following was noted: HD RN 1 signed in and completed hemodialysis on July 7, 2008. There was no online verification form for that date in the binder.</p>	{A 394}	<p>a. The Dialysis RN presents to the HS when reporting to the Hospital.</p> <p>b. For a dialysis nurse who presents for the first time to the Hospital, the HS:</p> <ul style="list-style-type: none"> i. Confirms the nurse's identification by asking to see government issued photo ID. ii. Performs primary source verification by accessing the California BRN website. iii. Initials the CaBRN print-out and places it in the dialysis nurse's file. <p>c. For a dialysis nurse who presents for duty on a subsequent shift, the HS pulls the nurse's file, confirms his/her identification by checking a government issued photo ID, and reviews the CaBRN license verification print-out on file.</p> <ul style="list-style-type: none"> i. If the license is current, no further action is necessary. ii. If the license has expired since the nurse's last shift worked, the HS performs primary source verification by accessing the CaBRN website, initials the print-out, and places it in the dialysis nurse's file. <p>d. The HS documents license verification on the log for each shift worked and maintains the log in the HS Office.</p> <p>e. If the dialysis RN does not have a current and valid California RN license, he/she is instructed to leave the Hospital, and the HS notifies the dialysis company of the situation and the immediate need for a replacement nurse.</p>	

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{A 394}	<p>Continued From page 21</p> <p>HD RN 2 signed in and completed hemodialysis on July 12, 2008. There was no online verification form for that date in the binder.</p> <p>HD RN 3 signed in and completed hemodialysis on July 11, 2008. There was no online verification form for that date in the binder.</p> <p>HD RN 4 signed in and completed hemodialysis on July 3, 2008. There was no online verification form for that date in the binder.</p> <p>HD RN 5 signed in and completed hemodialysis on June 13, 2008. There was no online verification form for that date in the binder.</p> <p>During an interview with the HS and the Director of Resource Management, on July 14, 2008, at 1:53 p.m., the Director stated initial first source verification of licensure was obtained on the nurses' initial visit. The on line verification was an additional step used to verify licensure on subsequent visits and to ensure the dialysis nurse did not "fall through the cracks," and not have a current license on file. The Director stated if the House Supervisor was not in the office when the dialysis nurse arrived, they were to page the HS before going to the unit.</p> <p>The House Supervisor's office at IVMC was entered on July 15, 2008, at 2:10 p.m.. The House Supervisor was not in the office, but ancillary staff was available.</p> <p>The dialysis binder for IVMC was reviewed on July 15, 2008. The binder included a sign in sheet for the HD RN and tabbed sections with individual HD RN's names. The following was noted: HD RN 5 signed in and completed hemodialysis on July 7, and 14, 2008. No online verification form for those dates was in the binder. HD RN 6 signed in and completed hemodialysis</p>	{A 394}	<p>4. Following receipt of the official CMS 2567 on 11/06/08 and review of this citation, the DON reviewed the logs used for dialysis nurse sign-in and license verification by the HSs. Because the DON identified small variances, the DON revised the logs for consistency.</p> <p>5. The DON educated the HSs on the revised process and the updated logs. In addition, the DON spoke with the Acute Regional Operations Director of the dialysis service to assure that the dialysis nurses were educated on the check-in and license verification process.</p> <p>6. The revised process applies to dialysis and other contracted nursing staff, such as registry RNs, who report for duty.</p> <p>7. In follow-up, the DON sent the Acute Regional Operations Director of the dialysis service the license verification process, sign-in log, and license verification log to assist with the service's orientation of dialysis nurses.</p> <p>MONITORING:</p> <p>1. The DON/designee does a random review of the check-in and license verification process on a monthly basis.</p> <p>2. Should a process variation be identified, the reviewer will address the issue with the HS.</p> <p>3. The DON/designee reviews and discusses feedback from the review process at the HS staff meetings. The CNE is responsible for further action should there be any concerns or questions regarding the license verification process.</p>	<p>11/15/08</p> <p>11/19/08</p> <p>11/20/08</p> <p>11/26/08</p> <p>11/21/08 & ongoing</p> <p>11/21/08 & ongoing</p> <p>11/21/08 & ongoing</p>	

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{A 394}	Continuation Page--	{A 394}	<p>REBUTTAL:</p> <p>While the Hospital agrees that it did not consistently follow the corrective action put in place following the 10/02/07 survey, it disagrees that it violated this rule for the following reasons.</p> <p>At the conclusion of the 10/02/07 survey, the Hospital wanted to bring heightened attention to this issue by assuring that dialysis nurses not only sign in with the House Supervisor (HS) each time they come to the Hospital to provide patient care services, but that the HS responsible for the new process is diligent in confirming that each dialysis nurse possesses a current California RN license. To that end, the original corrective action required the HS to obtain an online verification of the RN license each time the dialysis nurse checked in.</p> <p>During the survey of 07/17/08, all nursing staff (employed or contracted) had a valid and current RN license on file that was appropriately verified. This citation reflects that a portion of the process put into place following the 10/02/07 survey was not consistently followed.</p> <p>In the course of the 07/17/08 survey, Hospital leadership and the survey team discussed that the practice of performing primary source verification each time a dialysis nurse presents for a shift was not a regulatory requirement. Therefore, the Hospital revised its process as described above to comply with the practice, which was compliant with the rule.</p>	
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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM			STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562		
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A 395	Continued From page 23 1. On July 15, 2008, at 1:30 p.m., Patient 811's record was reviewed. The patient was admitted to the facility on July 10, 2008, with diagnoses that included left hip fracture. A facility document titled, "ACUTE CARE NURSING 24-HOUR FLOW SHEET," dated July 10, 2008, was reviewed. The LN documented at 11:25 p.m., "Assessment complete... Pt's has skin tear x 2 to (L) arm with gauze dressing..." There was no documentation indicating the LN notified the physician regarding the patient's skin tears. There was no C/P addressing the patient's skin tears. On July 15, 2008, at 2:15 p.m., an interview was conducted with the Director of Acute Medical Services. The Director was asked about the facility P&P addressing the LN's responsibility for of the ongoing reassessment. The director stated, "The nurse is responsible for re-assessing the patient and reporting her findings to the physician." The director further stated, "It is our policy for the nursing staff to re-assess the patient every shift." On July 15, 2008, at 2:20 p.m., an interview was conducted with the NM. The NM stated she was not aware the patient had skin tears on the left arm. The NM stated the LN should have removed the Kerlix wrap from Patient 811's left arm and then called the physician for wound care orders. The NM stated the facility P&P indicated the LN must re-assess the patient every shift and document the findings in the patient's record. The NM further stated, "We did not follow our P&P."	A 395	b. From that point until the patient was discharged after the survey, confirmed that, as part of the shift assessments for this patient, the RNs caring for the patient continued to document reassessment of the wound and applied the Neosporin ointment daily as prescribed. The reassessments leading up to discharge document that the wound was healing with no redness or drainage. c. Reviewed and confirmed the policy for reassessment, documentation and care planning d. Had several nurses attend a wound care course in order to serve as a resource to other staff on wound care issues. The Director of Acute Medical Services and the Director of Critical Care reviewed skin assessment/reassessment procedures and skin care for med/surg and ICU nurses at various staff meetings through the fall 2008. The Director of Education arranged for a Wound Care class onsite for nursing staff to reinforce assessment/reassessment and care of wounds. MONITORING: The Director of Acute Medical Services implemented the following monitoring: a. The Med-Surg Managers conduct a chart review of patients with wounds to assure that the nurses comply with the assessment/reassessment policy and that the plan of care includes a complete entry for skin integrity. b. The Med-Surg Manager is responsible for addressing variances from policy with the specific individual(s) to correct the identified	07/24/08 07/25/08 07/31/08 11/30/08 11/06/08 12/01/08 & ongoing 12/01/08 & ongoing	

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A 395	<p>Continued From page 24</p> <p>On July 15, 2008, at 2:25 p.m., an interview was conducted with the LN assigned to Patient 811. The LN was asked about the Kerlix wrap on Patient 811's left arm. The LN stated, "I did not remove the Kerlix on the left arm, I don't know what the wound looks like."</p> <p>A facility document titled, "ASSESSMENT/REASSESSMENT OF PATIENT," and revised on January 2006, was reviewed on July 15, 2008. *POLICY: ASSESSMENT OF PATIENT</p> <p>A. An initial assessment of each patient's physical, psychological, nutritional status, functional status, pain management needs, and social status is completed by an RN at time of admission.</p> <p>i. Each patient is re-assessed at regularly specified times related to the patient's course of treatment: NURSING STAFF: at least every shift....."</p> <p>2a. On July 15, 2008, Patient 301's record was reviewed. Patient 301 was admitted to the facility on July 12, 2008, with diagnoses that included mental retardation, renal failure, diabetes mellitus, stage II decubitus ulcer and neglect. Patient 301's physician's orders included acute dialysis for July 14, 2008. Patient 301's initial weight was not documented on the facility's Admission Data Base Form. The Admission Data Base Form contained blank spaces for height and weight. Next to these spaces were * (asterisks) and a notation that indicated the height and weight "Must be completed."</p> <p>Further review of the record indicated two different weights for Patient 301. The Emergency Room Record for July 12, 2008, at 2:09 p.m.,</p>	A 395	<p>concern and provide appropriate coaching.</p> <p>c. The Director of Acute Medical Services provides an overview and analysis of aggregate data at the unit staff meetings to gain staff input and take action as appropriate to the findings.</p> <p>The Director of Critical Care Services implemented the following monitoring:</p> <p>a. The Managers of the ICU conduct a monthly audit of shift report assessment of patient skin.</p> <p>b. The ICU Manager is responsible for addressing audit results with the staff at monthly staff meetings as well as with individual employees to improve performance as indicated.</p> <p>REBUTTAL:</p> <p>The Hospital nevertheless respectfully submits that the citation of failure to follow policy completely for one of 112 records does not support a finding of substantial noncompliance with this rule.</p> <p>2. ASSESSMENT OF WEIGHT:</p> <p>CORRECTIVE ACTION:</p> <p>To assure that a patient's weight is documented on admission, and as indicated at intervals during the patient's stay, the Hospital took the following actions:</p> <p>a. The Director of Acute Medical Services educated Med-Surg staff regarding the Hospital's policy and resources available to obtain patient weights and reviewed the importance of accurate weights as it relates to</p>	12/01/08 & ongoing 12/01/08 & ongoing 12/01/08 & ongoing 08/31/08

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A 395	<p>Continued From page 25</p> <p>indicated the patient weighed 49.9 KG (99.8 lbs). The patient's Clinical Profile indicated the patient's weight was 56 kg (123.4 lbs).</p> <p>During an interview with the Director of Acute Medical Services and the Risk Manager on July 15, 2008, at 9:30 a.m., the Director stated the weight documented in the Clinical Profile was submitted to the Pharmacy, Dietary and Nursing Departments for use when a patient's weight is required. The Risk Manager stated the weight from the Clinical Profile does not "interface," with the clinical record. The Risk Manager stated Patient 301's weights were different because, they were an estimated weight, which was inputted into the computer at different times. They were unable to find an accurate admission weight for Patient 301.</p> <p>b. On July 15, 2008, Patient 314's record was reviewed. Patient 314 was admitted to the facility on July 1, 2008. Patient 314's initial weight was not documented on the facility's Admission Data Base Form. The Admission Data Base Form contained blank spaces for height and weight. Next to these spaces were * (asterisks) and a notation that indicated the height and weight "Must be completed."</p> <p>The facility's policy and procedure titled "Nursing Procedures, Clinical," with a revision date of May 2008, was reviewed on July 16, 2008. The policy indicated the CNO in conjunction with the Clinical Educators approved a reference tool to provide standards for clinical nursing procedures. The reference was documented as "Lippincott's Nursing Procedures, Fifth Edition." In the section for Fundamental Procedures the following was documented in the section titled Height and</p>	A 395	<p>medication dosing, nutritional assessments, CHF and renal patients.</p> <p>b. At the October staff meeting, the Director of Acute Medical Services reviewed this issue and reminded staff about the need to obtain and document an Admission weight.</p> <p>c. The Med-Surg Nursing leaders created a PI plan for patient admission weights whereby the unit managers perform periodic open record reviews of the Admission Database to confirm that patient weights are recorded. If the weight is not documented, the manager addresses the issue with the patient's nurse and a weight is done and documented.</p> <p>d. The Director of Acute Medical Services educated the staff from the contracted dialysis service regarding the need to document patient weights when ordered by the physician or as clinical status warrants for patients who are being are dialyzed.</p> <p>e. After receiving the official CMS 2567 on 11/06/08 and reviewing this citation, to consolidate policy information related to patient weights in a single location, the Director of Acute Medical Services drafted a new nursing policy, "Weights, Obtaining Inpatient Adult and Pediatric". The policy was routed for review. Input was sought from the Nephrologists, who indicated that pre and post dialysis weights are not always indicated. The physicians advised the Director that the more important clinical data element is the amount of fluid removal. The Director revised the Dialysis Policy to make clear pre and post dialysis weights are NOT required unless ordered by the nephrologist or other physician.</p> <p>f. The Policy & Procedure Committee approved the new policy.</p>	10/31/08 09/30/08 08/31/08 11/26/08 11/28/08	

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{A 395}	Continuation Page--	{A 395}	<p>g. The Acute Regional Operations Director for the dialysis service confirmed to the DON that she provided the dialysis nurses with a written flyer describing the expectation for documenting patient weights when ordered. The dialysis nurse seeks assistance from the patient's primary nurse if an actual weight is ordered and needs to be done pre- and post-dialysis.</p> <p>MONITORING:</p> <p>a. The Med-Surg Managers conduct a monthly chart review to confirm that patient weights are documented per policy. The review checks that admission weights are being done and documented, and that ongoing weights are documented for dialysis patients when ordered by a physician.</p> <p>b. The Med-Surg Managers are responsible for correcting and coaching individuals when they find variance from the policy.</p> <p>c. The Director of Acute Medical Services analyzes and presents aggregate data at the unit staff meetings to gain staff input and to take appropriate action to address the findings.</p>	11/26/08 12/01/08 & ongoing 12/01/08 & ongoing 12/01/08 & ongoing

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{A 398}	<p>Continued From page 27 treatment.</p> <p>Findings:</p> <p>1. On July 14, 2008, at 11 a.m., Patient 301 was observed in bed, undergoing hemodialysis.</p> <p>During an interview with HD RN 1, on July 14, 2008, 11 a.m., he stated he was not employed by the hospital, but was employed by an agency that contracted with the hospital. HD RN 1 stated he checked in at the staffing office when he arrived.</p> <p>On July 15, 2008, Patient 301's record was reviewed. Patient 301 was admitted to the facility on July 12, 2008, with diagnoses that included mental retardation, renal failure, diabetes mellitus, stage II decubitus ulcer and neglect. Patient 301's physician orders included acute dialysis for July 14, 2008. Patient 301's initial weight was not documented on the facility's Admission Data Base Form. Further review of the record indicated two different weights for Patient 301. The Emergency Room Record for July 12, 2008, at 2:09 p.m., indicated the patient weighed 49.9 KG (99.8 lbs). The patient's Clinical Profile indicated the patient's weight was 56 kg (123.4 lbs). A review of the Hemodialysis Record completed for July 14, 2008, indicated blank spaces where the patient's weight was to be documented.</p> <p>During an interview with the Director of Acute Medical Services on July 15, 2008, at 9:30 a.m., the Director stated she would expect pre and post dialysis weights be obtained. The Director further stated if patient weight was not available to the HD RN, facility staff should be notified and weight obtained.</p>	{A 398}	<p>c. The Med-Surg Nursing leaders created a PI plan for patient admission weights whereby the unit managers perform periodic open record reviews of the Admission Database to confirm that patient weights are recorded. If the weight is not documented, the manager addresses the issue with the patient's nurse and a weight is done and documented.</p> <p>d. The Director of Acute Medical Services educated the staff from the contracted dialysis service regarding the need to document patient weights when ordered by the physician or as clinical status warrants for patients who are being are dialyzed.</p> <p>e. After receiving the official CMS 2467 on 11/06/08 and reviewing this citation, to consolidate policy information related to patient weights in a single location, the Director of Acute Medical Services drafted a new nursing policy, "Weights, Obtaining Inpatient Adult and Pediatric". The policy was routed for review. Input was sought from the Nephrologists, who indicated that pre and post dialysis weights are not always indicated. The physicians advised the Director that the more important clinical data element is the amount of fluid removal. The Director revised the Dialysis Policy to make clear pre and post dialysis weights are NOT required unless ordered by the nephrologist or other physician.</p> <p>f. The Policy & Procedure Committee approved the new policy.</p>	<p>09/30/08</p> <p>08/31/08</p> <p>11/26/08</p> <p>11/28/08</p>

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(A 398)	Continued From page 28 The facility's policy and procedure titled "Nursing Procedures, Clinical," with a revision date of May 2008, was reviewed on July 16, 2008. The policy indicated the CNO in conjunction with the Clinical Educators approved a reference tool to provide standards for clinical nursing procedures. The reference was documented as "Lippincott's Nursing Procedures, Fifth Edition." In the section for Hemodialysis the following was documented in the section titled Implementation: "Weigh the patient. To determine ultra filtration requirements, compare his present weight to his weight after the last dialysis and his target weight." 2. On July 15, 2008, Patient 314's record was reviewed. Patient 314 was admitted to the facility on July 1, 2008. Patient 314 was started on hemodialysis on July 6, 2008, for acute renal failure. A review of the Hemodialysis Records for July 13 and 15, 2008, revealed pre and post dialysis weights were not documented. The facility's contracted dialysis service's policy and procedure for "Treatment Initiation Patient Assessment," dated June 2006, was reviewed on July 16, 2008. The policy indicated the purpose was "to obtain information for planning the dialysis treatment and for assessing the patient's response to the treatment." The policy indicated the HD RN should "obtain and document basic data on each patient pre dialysis." The policy indicated "Assessment data may include, but is not limited to, the following: weight..." The facility's policy and procedure titled "Nursing Procedures, Clinical," with a revision date of May 2008, was reviewed on July 16, 2008. The policy indicated the CNO in conjunction with the Clinical	(A 398)	g. The Acute Regional Operations Director for the dialysis service confirmed to the DON that she provided the dialysis nurses with a written flyer describing the expectation for documenting patient weights when ordered. The dialysis nurse seeks assistance from the patient's primary nurse if an actual weight is ordered and needs to be done pre- and post-dialysis. MONITORING: a. The Med-Surg Managers conduct a monthly chart review to confirm that patient weights are documented per policy. The review checks that admission weights are being done and documented, and that ongoing weights are documented for dialysis patients when ordered by a physician. b. The Med-Surg Managers are responsible for correcting and coaching individuals when they find variance from the policy. c. The Director of Acute Medical Services analyzes and presents aggregate data at the unit staff meetings to gain staff input and to take appropriate action to address the findings.	11/26/08 12/01/08 & ongoing 12/01/08 & ongoing 12/01/08 & ongoing
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A 467	<p>Continued From page 30 appropriate therapies.</p> <p>Findings:</p> <p>Patient 301's record was reviewed on July 15, 2008. The record revealed Patient 301 was a 76 year old female admitted to the facility on July 12, 2008, with diagnoses including renal failure, elderly neglect, and diabetes. Patient 301 had two stage II pressure ulcers and was receiving hemodialysis treatment three times per week. Dialysis is described in the dictionary as a "mechanical process that partly performs the work that healthy kidneys normally do. The main functions of dialysis include clearing wastes from the blood; restoring proper balance of certain electrolytes in the blood; and eliminating extra fluid from the body."</p> <p>There was a nutrition assessment conducted by the RD on July 13, 2008, in which she assessed Patient 301 at 83 % of her ideal body weight range (120-143lbs). Patient 301's BMI was 17.3. BMI (Body mass Index) is an indicator of nutritional health and a BMI of less than 18.5 for women is considered underweight. The RD classified her to be at "moderate to severe nutritional risk related to low BMI, poor dentition, skin breakdown..." There were recommendations made for additional nutritional supplements to "help wound healing, albumin..."</p> <p>Patient 301's physician's orders included acute dialysis for July 14, 2008. According to MST nursing staff at RSMC, the dialysis service was a contracted service. Hemodialysis treatment was provided on July 14, 2008. Review of the Hemodialysis Record dated "July 14, 2008," indicated dashes (-) in the columns for pre and</p>	A 467	<p>c. The Med-Surg Nursing leaders created a PI plan for patient admission weights whereby the unit managers perform periodic open record reviews of the Admission Database to confirm that patient weights are recorded. If the weight is not documented, the manager addresses the issue with the patient's nurse and a weight is done and documented.</p> <p>d. The Director of Acute Medical Services educated the staff from the contracted dialysis service regarding the need to document patient weights when ordered by the physician or as clinical status warrants for patients who are being are dialyzed.</p> <p>e. After receiving the official CMS 2567 on 11/06/08 and reviewing this citation, to consolidate policy information related to patient weights in a single location, the Director of Acute Medical Services drafted a new nursing policy, "Weights, Obtaining Inpatient Adult and Pediatric". The policy was routed for review. Input was sought from the Nephrologists, who indicated that pre and post dialysis weights are not always indicated. The physicians advised the Director that the more important clinical data element is the amount of fluid removal. The Director revised the Dialysis Policy to make clear pre and post dialysis weights are NOT required unless ordered by the nephrologist or other physician.</p> <p>f. The Policy & Procedure Committee approved the new policy.</p>	<p>09/30/08</p> <p>08/31/08</p> <p>11/26/08</p> <p>11/28/08</p>
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{A 500}	Continued From page 33 Springs Medical Center (RSMC). There was a written physician's order dated July 11, 2008, at 5:30 p.m., for NTG (nitroglycerin) drip to start at 7mcg/min and titrate to maintain SBP less than or equal to 120. A review of the MAR for July 11, 2008, documented NTG was given, as evidenced by the time written and the initial of the administering staff. A review of ICU/PCU Flow Sheet which documented the flow rate of the NTG every hour contained the following for the NTG given from July 11, 2008, at 6 p.m., to July 12, 2008, at 7 a.m.: 6 p.m. - 7 mcg; 7 p.m. - 7 mcg; 8 p.m. - 10 mcg; 9 p.m. - 15 mcg; 10 p.m. - 18 mcg; 11 p.m. - 18 mcg; 12 p.m. - 18 mcg; 1 a.m. - 18 mcg; 2 a.m. - 18 mcg; 3 a.m. - 18 mcg; 4 a.m. - 18 mcg; 5 a.m. - 18 mcg, and; 6 a.m. - 15 mcg. On July 14, 2008, at 3 p.m., a review of Pharmacy order entry revealed the directions for NTG for Patient 507 were entered as follows: "Start at 7 mcg/min, titrate as per UHS Guidelines to keep SBP less than or equal to 120." On July 14, 2008 at 4 p.m., a review of a document titled, "SWHCS Guidelines for IV Titration Drips in ICU-ED-PACU," which was also	{A 500}	incremental adjustment parameters, and maximum rates. The Forms Committee discussed and supported the draft Titration Order Form. c. The Special Care Committee reviewed the draft Titration Order Form and sought input from both physician and nursing end-users of the form. d. The draft form, incorporating user input, was submitted for form design. e. The Special Care Committee approved the form proof. f. The P&T Committee reviewed, revised, and approved the IV Guideline Attachment to Policy #14, Intravenous Therapy-Medications Given Intravenously by a Registered Nurse. g. The Director of Pharmacy/designee educated staff on the preprinted titration order form. h. The preprinted Titration Order form was implemented on the nursing units. MONITORING: a. The pharmacist monitors titration orders when received to ensure that the order includes the required elements. b. Should the pharmacist identify an incomplete order, the pharmacist is responsible for contacting the physician to discuss the issue and the clinical status of the patient, and to obtain a complete titration order.	08/22/08 10/03/08 10/19/08 10/22/08 10/24/08 11/05/08 11/06/08 & ongoing 11/06/08 & ongoing	

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{A 500}	Continued From page 34 referred to UHS Guidelines documented the following: "Nitroglycerin Incremental Rate Adjustment: 5 mcg/min every 3-5 min." On July 14, 2008 at 4:15 p.m., a review of the hospital's Policy and Procedures titled "Medication: Ordering, Transcription and Administration of," documented the following: "A. Medication Order Initiation: 4. The following elements must be present in any medication order, including... d. Frequency of administration/rate 8. Specific Order Types; c. Titrate orders: order to dose a drug to a specific parameter (i.e. BP) by incremental rate increases. Execution of titrate orders will be guided by approved dosing guidelines (policy NUR-14) that specify correct start rate, how to adjust rates, etc." On July 14, 2008, at 2:30 p.m., during an interview with the DOP and RN 500, they both stated the Physician's NTG order for Patient 507 was incomplete. The DOP and RN 500 stated the titration parameter was not specific enough and that it was their expectation the order should have been clarified by nursing or pharmacy staff by contacting the ordering Physician. The DOP and RN 500 stated the staff nurse who titrated the NTG drip did not follow the guideline for NTG as evidenced by the rate increase from 7 mcg/min to 10 mcg and from 15 mcg to 18 mcg as documented on the ICU/PCU Flow Sheet.	{A 500}	c. The DOP reports aggregate data at the P&T Committee meeting for analysis, action planning and follow-up as appropriate.	12/05/08 & ongoing	
{A 622}	482.28(a)(3) COMPETENT DIETARY STAFF There must be administrative and technical personnel competent in their respective duties.	{A 622}			

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{A 622}	Continued From page 35 This STANDARD is not met as evidenced by: This is a repeat deficiency. Based on observation, staff interview and review of hospital policy and procedure, the hospital failed to ensure that a dietary staff knew how to properly check the chemical concentration of the sanitizer in a three-compartment sink. This failure resulted in inadequate sanitization of food service equipment and utensils. Findings: During a kitchen tour at IVMC, at approximately 2:15 p.m., on July 16, 2008, a dietary aide who was washing pots and pans and other food service utensils was asked to test the water for quaternary ammonia in the final rinse sink of the three compartment sink. The dietary aide tested the water twice using a test strip. Both times the test strip indicated quaternary ammonia levels of about 100 ppm. The proper concentration for quaternary ammonia for effective sanitization is 200 ppm. The dietary aide was interviewed at approximately 2:20 p.m., on July 16, 2008. The aide stated she had changed the water, making a fresh solution, about ten minutes earlier. The aide stated she had pumped the sanitizer into the water, in the manner that she had been trained. The sink compartment was approximately 7/8th full. The volume of water in the sanitizing compartment	{A 622}	CORRECTIVE ACTION: To improve the process for preparing and checking the chemical concentration of the sanitizer in the three-compartment sink and to minimize the need for repeated "test strip" checks of the sanitizer concentration, the Food Service Manager (FSM) took the following actions: a. Based upon the capacity of the sink, a water fill line was marked on the inside of the sink to assist all employees in filling the sink with a consistent volume of water. The mark on the interior of the sink increases visibility for the staff and enhances accuracy. b. The FSM is responsible for checking the sink fill line during daily rounds and remarking the sink as needed. c. The FSM calculated the amount of sanitizer necessary to achieve effective sanitation (200 ppm) consistent with the manufacturer's recommendations and determined that five (5) pumps of the sanitizer are necessary to achieve effective sanitation. For added safety, the dietary staff is responsible for confirming the chemical concentration with the test strip prior to use. d. The FSM/designee provided staff education by verbally reviewing with dietary staff the process necessary to achieve proper sanitizing levels. e. The FMS had signs posted over the sink to explain the proper procedure. f. In addition, the FSM verified staff competency by direct observation. g. The FSM/designee provided formal inservice for the dietary staff to reinforce the proper sanitizing process.	07/17/08 07/17/08 & ongoing 07/17/08 07/31/08 07/31/08 07/31/08 10/25/08	

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{A 622}	Continued From page 36 was excessive for the amount of sanitizer that the aide indicated she had pumped into the water. The aide was unable to state the amount of water needed to mix with the sanitizer. Instructions posted on the wall above the sink indicated the amount of water to be placed in the sink. The instruction did not match the amount of water added to the sink by the dietary aide. The volume of water indicated by a waterline marked on the exterior of the sink was less than what the diet aide had filled the sink with or the picture on the wall. During an interview with the Food Service Manager and Director of Food and Nutrition, at approximately 2:30 p.m., on July 16, 2008, they stated the hospital did not have a policy that specified the volume of water to match the amount of sanitizer. A review of the policy and procedure titled "Dishes and Silverware," on July 16, 2008, confirmed the hospital had not determined the specific volume of water that was needed to match the amount of sanitizer pumped into the sink. The Food Service Manager stated this aide and other aides were trained to add sanitizer and use the test strip to monitor sanitizer levels, until the correct concentration was achieved. The facility failed to ensure staff used adequate sanitizer in the sink, resulting in food service equipment and utensils being improperly sanitized.	{A 622}	h. After receiving the official CMS 2567 and reviewing this citation, the DFN reviewed and revised Dietary Policy #D4, "Dishes and Silverware" to assure that the content was accurate and current and to include information related to the fill line. The policy was routed for review and approved by the Policy and Procedure Committee. MONITORING: a. The FSM confirmed that compliance with safe food handling is part of each aide's job description and is reflected in his/her annual evaluation. The FSM is responsible for formally evaluating each dietary staff member's compliance with policy, including the requirement for safe food handling, on an annual basis. Annual evaluations were done during the month of June for all hospital employees, including the dietary staff. b. The FSM or the Dietary Leads monitor the sanitation and dish sink logs daily. Any variances identified in the review are discussed immediately with the staff involved. Aggregate data is incorporated into the Dietary PI report which forwards to the Operational PI Committee on a quarterly basis. c. The FSM and Dietary Leads conduct random, unannounced observations of kitchen staff performing this process during department rounds to ensure ongoing compliance. Direct feedback is provided to the employee during rounds.	11/25/08 08/01/08 & ongoing 08/01/08 & ongoing 08/01/08 & ongoing
{A 628}	482.28(b) MENUS Menus must meet the needs of the patients.	{A 628}		

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{A 628}	Continued From page 37 This STANDARD is not met as evidenced by: This is a repeat deficiency. Based on observation, staff interview and review of hospital menus, food production sheets, recipes, and the hospital diet manual, the facility failed to ensure meals were served to patients at RSMC according to the recipe, resulting in 52 patients receiving less food than was planned by the dietitian. The hospital also failed to ensure the menu for patients on pureed diets were properly planned to allow variety, resulting in these patients receiving the same main entrée every lunch or dinner. Findings: 1. Tray line observation on July 14, 2008, at 12 p.m., revealed that patients who received Rosa's Beef Burgundy with Parsley Noodles and Gravy were served 4 oz each. This entrée had vegetables including peas, potatoes, carrots, tomatoes, onions and mushroom. The entrée had very little beef. The community standard for a regular portion size for a combination dish (entrée with meat and vegetable and/or starch cooked together) was 6-oz. At approximately 1:30 p.m., on July 14, 2008, the observation made regarding very little beef in the lunch entrée was shared with the DFN services. A review of the food production sheet did not indicate either a portion size or serving utensil for the regular Beef Burgundy. The portion sizes and serving size for the LS and renal portions of the Beef Burgundy were listed as 4-oz. The serving size was listed as a 4-oz spoon. Review of the recipe for Beef Burgundy confirmed the serving size for the entrée should be 6-oz. Therefore, all	{A 628}	1. PORTION SIZE: CORRECTIVE ACTION: In order to assure that the menus meet the nutritional needs of patients related to a regular portion size in accordance with the recipe, the hospital took the following actions: a. The Director of Food & Nutrition (DFN) met with the dietary staff during the survey to correct and address the verbal findings concerning portion size. b. The Food Service Manager (FSM) reviewed the daily production sheets for the various diets and had the information updated / revised to include the portion size with identification of the proper serving utensil to assure that the portion size is consistent with the dietitian's menu planning. c. The FSM confirmed that the production sheets are located in the Diet Office. As the diet clerk is responsible for tallying the patient selections for the day, the clerk completes the production sheet for the cook so the cook has the information necessary to prepare the correct amount of servings in each menu category. d. The FSM confirmed that when the diet clerk or dietitian does patient rounding they assist patients with menu selection. Food preferences are discussed and noted on the patient's dietary kardex. Based upon the patient's prescribed diet and the patient's menu selection, the tray is prepared. If the patient does not select an item in each category, there is a standard selection identified on the menu that is prepared and provided. In this manner, and with their input, patients receive adequate calories and nutrition consistent with the physician's order.	07/17/08 08/04/08 08/04/08 08/04/08

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{A 628}	<p>Continued From page 38</p> <p>52 patients received less food than was planned by the dietitian.</p> <p>The cook was interviewed on July 14, 2008, at approximately 1:35 p.m. She stated she was unaware that the portion size for the entrée should have been 6-oz. The cook stated she used the 4-oz spoon because the food production sheet indicated a 4 oz spoon was used for the LS and renal diets.</p> <p>During the same interview on July 14, 2008, at 1:35 p.m., the DFN stated she was surprised there were errors on the production sheet, as she had directed the food service manager to review the menu and production sheets and make the appropriate corrections.</p> <p>Based on the nutrient analysis of the entrée, the 6-oz portion would have provided 21.2 grams of protein and 307 calories. According to the DFN, the 4oz serving served to patients provided 205 calories and 14 grams of protein. Based on her calculation, it would appear that patients received approximately 102 less calories and 7 less grams of protein. This nutrient analysis was based on the recipe with potatoes, but the facility's entrée was prepared without potatoes. According to a note on the recipe, by omitting the potatoes, the dish could be served to patients on renal and diabetic diets. The 52 patients that received the Beef Burgundy received greater than 102 less calories per entrée than was planned to meet their needs.</p> <p>2. Based on observation during lunch on July 14, 2008, and interview with the DFN on the same day at approximately 12:35 p.m., the hospital utilized only preformed beef and chicken for</p>	{A 628}	<p>MONITORING:</p> <p>To monitor that meals are created with the correct portion size and in accordance with the recipe, the Hospital took the following actions:</p> <p>a. The dietitian or the lead diet clerk performs tray checks to assure appropriate portion size. The dietitian addresses a staff member's concern regarding the content of the tray so it is resolved before the tray leaves the kitchen. The DFN provides feedback on the overall findings of tray line checks to the dietary staff at the unit based staff meetings. The DFN added tray line checks to the department's QC Report beginning 3rd quarter 2008; these reports also go to the Operational PI Committee.</p> <p>b. To facilitate the patient's participation in the nutritional plan of care, the Diet Clerk seeks patient input during the 1:1 interviews that occur during the menu selection process. The Dietitian when rounding also seeks patient input. In addition, the DFN coordinates a patient satisfaction survey informally, using a hospital tool. An outside contractor also assesses patient satisfaction with dietary services as part of the hospital-wide patient satisfaction survey. The DFN or FSM presents the results of these surveys at the unit-based staff meetings and is responsible to take action to address identified opportunities for improvement.</p>	08/01/08 &ongoing 08/01/08 & ongoing

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{A 628}	Continuation Page--	{A 628}	<p>2. PUREE DIETS:</p> <p>CORRECTIVE ACTION:</p> <p>a. Using the information provided in the Diet Manual approved by the P&T Committee on 10/24/2007, the Director of Food and Nutrition (DFN) developed new puree menus to provide variety so the patients can select their food choices in the usual menu categories. The menus themselves vary and are not the same on a day-to-day basis.</p> <p>b. Dietary staff round on patients with a puree diet to interview them relating to their food preferences. Patient requests for the onsite preparation of puree foods (hospital provided) are honored when they are consistent with the patient's prescribed diet and the requested item can be prepared in a timely manner.</p> <p>c. During the pre-formed puree product ordering process, the DFN reviews new product options as appropriate for inclusion as additional items for the puree menu.</p> <p>d. Following receipt of the official CMS 2567 on 11/06/08 and review of this citation, the DFN reviewed and revised the Dietary Policy #D2, "Diet Office Procedures" to incorporate the changes related to the puree menu. The policy was approved by the Policy & Procedure Committee. The DFN educated dietary staff on the revised policy.</p> <p>MONITORING:</p> <p>Tray checks:</p> <p>a. The dietitian or the lead diet clerk performs tray checks to assure adequacy and variety for all patients with a puree diet order.</p>	<p>07/17/08</p> <p>07/17/08</p> <p>07/17/08 & ongoing</p> <p>11/25/08</p> <p>07/17/08 & ongoing</p>

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{A 628}	Continued From page 39 patients on pureed diets. The patients did not receive a menu to make a diet selection. The cook was interviewed on July 15, 2008, at approximately 11:45 a.m. The cook stated for dinner the previous day, patients on pureed diets received the preformed pureed chicken. The cook further stated she had prepared and planned to serve the pureed chicken, green beans and mashed potato for lunch July 15, 2008. This was exactly the same entrée vegetable and starch served the day before for lunch. During the same interview, the cook was asked what was planned for dinner. The cook stated patients on pureed diets would also receive pureed beef, pureed zucchini and mashed potatoes for dinner that evening, thereby receiving the same entrée and mashed potato on two consecutive days for the same meal. While patients on pureed diets received little variety, patients on regular diets (according to the menu) had the choice of Turkey noodle casserole, cottage cheese and fresh fruit plate or tuna salad sandwich for lunch; and yogurt baked chicken breast or roast pork with cinnamon applesauce and natural gravy for dinner. The DFN was interviewed on July 15, 2008, at 12:45 p.m., and asked why the pureed form of the regular diet could not be prepared to decrease the monotony of the pureed diet meals. The DFN stated the hospital was working to increase the appeal of the food by using a standardized commercial item that looked like the "real" food.	{A 628}	b. The dietitian addresses a staff member's concern regarding the content of the tray so it is resolved before the tray leaves the kitchen. c. The DFN provides feedback on the overall findings of tray line checks to the dietary staff at the unit-based staff meetings. d. The DFN added tray line checks to the department's QC Report beginning 3rd quarter 2008; these reports also go to the Operational PI Committee. Patient Input: a. The diet clerk seeks patient input during the 1:1 interviews that occur during the menu selection process. b. The dietitian when rounding also seeks patient input. c. In addition, the DFN coordinates a patient satisfaction survey informally, using a hospital tool. d. An outside contractor also assesses patient satisfaction with dietary services as part of the hospital-wide patient satisfaction survey. e. The DFN or Food Service Manager presents the results of these surveys at the unit-based staff meetings and is responsible to take action to address identified opportunities for improvement.	08/01/08 & ongoing
{A 630}	482.28(b)(2) DIETS Nutritional needs must be met in accordance with	{A 630}		

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{A 630}	Continued From page 40 recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the patients. This STANDARD is not met as evidenced by: Based on observation, staff interview and review of hospital menu, food production sheets, recipes, and the hospital diet manual, the facility failed to ensure that the diets served met the nutritional needs for two of two patients (Patients 301 and 601) on pureed diets at RSMC, resulting in the potential for weight loss due to inadequate calories and nutrients for both patients on pureed diets. Findings: Review of the lunch menu on July 14, 2008, at 12 p.m., indicated that the following items were offered to patients on the regular diet: Beef broth or cream of mushroom soup, Rosa's Beef Burgundy with Parsley Noodles and gravy or Tuna Salad, Vegetable Medley or Carrots, a variety of desserts and beverages. Review of the menu for patients receiving a pureed diet indicated the patients should have received pureed Beef Burgundy, pureed/strained vegetable medley, mashed potato and gravy and cream of wheat. During tray line observation on July 14, 2008, at	{A 630}	CORRECTIVE ACTION: In order to assure that patients on a pureed diet are served diets that meet their nutritional needs, the Hospital took the following action: 1. Using the information provided in the Diet Manual approved by the P&T Committee on 10/24/2007, the Director of Food and Nutrition (DFN) developed new puree menus to designed to provide adequate nutrition and variety so the patients can select their food choices in the usual menu categories. 2. The DFN had provided to dietary staff education and clarification of expectations regarding preparation and correct servings of a balanced meal to assure that the cook prepared all elements of the puree menu and patients on a puree diet were provided the correct amount of calories as prescribed. 3. Dietary staff round on patients with a puree diet to interview them relating to their food preferences. Patient requests for homemade puree foods are honored when they are consistent with the patient's prescribed diet and the requested item can be received and prepared in a timely manner. 4. The DFN confirmed that the dietitian monitors patients at risk for chewing/swallowing problems at least two (2) times per week, and patients at high risk, at least three (3) times per week. Patients whose nutritional needs are being met are assessed at low risk, with monitoring done at least once per week.	07/17/08 07/17/08 07/17/08 07/17/08	

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{A 630}	<p>Continued From page 41</p> <p>approximately 12 p.m., the patients on pureed diets did not receive the items listed on the menu. The patients on pureed diets were served the following: a preformed serving of pureed roast beef, preformed portion of green beans and a serving of mashed potato with gravy boost and thickened apple juice and milk. They were not served cream of wheat. The diet was missing soup or items on the appetizer category of the regular diet.</p> <p>a. On July 14, 2008, a review of the record for Patient 301 revealed Patient 301 was a 76 year old female admitted to the facility on July 12, 2008, with diagnosis including renal failure, elderly neglect, and diabetes. Patient 301 was 63 inches tall and weighed 49.9 kg or 109.78 lbs. The Registered Dietitian assessed her at 83% of her ideal body weight. The dietician classified patient 301, as a moderate or severe nutritional risk based on her nutritional status including the fact that she was underweight. Patient 301's physician ordered a 2000 calorie pureed diet with thin liquids.</p> <p>b. Patient 601's clinical record was reviewed on July 16, 2008. Patient 601 was admitted on July 9, 2008. Patient 601 was 5'11" tall and weighed 160 lbs. The RD assessed him at 93% of his ideal body weight range of 157 -189 lbs. Physician's orders included a pureed diet with honey thick liquids.</p> <p>Both patients were served pureed beef, pureed green beans and mashed potato. Neither patient received the soup or the cream of wheat. They received fewer calories than was planned on the diet.</p>	{A 630}	<p>5. The DFN reviews new product options when pre-formed puree products are ordered and determines if they are appropriate additional items with adequate calories for the puree menu.</p> <p>6. The Food Service Manager (FSM) reviewed the daily production sheets for the various diets, including the puree diet. The information was updated / revised to include the portion size with the proper serving utensil to ensure that the portion size is consistent with the dietitian's menu planning.</p> <p>7. The FSM confirmed the production sheets are located in the Diet Office. As the diet clerk tallies the patient selections for the day, the production sheet is completed for the cook so the cook has the information necessary to prepare the correct amount of servings in each menu category.</p> <p>8. When the diet clerk or dietitian round on patients, they are responsible for assisting with menu selection, discussing food preferences, and noting them on the patient's dietary kardex. Based upon the patient's prescribed diet and the patient's menu selection, the cook prepares the tray. If the patient does not select an item in each menu category, which may result in an inadequate number of calories on the tray, there is a standard selection made from the appropriate menu categories that is prepared and provided.</p> <p>9. After receiving the official CMS 2567 on 11/06/08 and reviewing this citation, the FSM reviewed and revised Dietary Policy #D2, "Diet Office Procedures" to incorporate the changes related to the puree menu. The Policy & Procedure Committee approved the revisions.</p>	<p>07/17/08 & ongoing</p> <p>08/04/08</p> <p>08/04/08</p> <p>08/04/08</p> <p>11/25/08</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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) COMPLETION DATE	
{A 630}	Continued From page 42 According to the information provided by the Director of Food and Nutrition on July 15, 2008, at 12:45 p.m., the pureed diet should provide approximately 2945 calories per day with approximately 1095 calories from lunch from four categories. The entrée (chicken or beef), fruit, vegetable, strained soup would provide approximately 475 calories, country bread would provide 160 calories Boost pudding 240 calories, thickened milk and juice 220 calories. On July 15, 2008, the manufacturer's nutritional information for the preformed beef and vegetables was reviewed. The preformed meal items provided fewer calories than pureed items from the facility's regular diet. The preformed pureed beef was 140 calories, preformed pureed green beans was 90 calories with approximately 100 calories from the mashed potato, a total of 330 calories. Patients on pureed diet received approximately 150 less calories than was planned on the menu for that meal. The Director of Food and Nutrition indicated during an interview on July 14, 2008, at approximately 12:40 p.m., the hospital had changed to the preformed several months earlier. It is unclear how long the caloric deficits may have existed in the diets of patients on pureed diets because the food production sheets did not direct the cook to prepare both the strained soup and country bread described in the diet manual or the cream of wheat listed on the menu.	{A 630}	MONITORING: 1. The dietitian or the lead diet clerk performs daily tray checks to assure the adequate number of calories are provided and there is a variety with the puree diet orders. Trays must have the appropriate portion size serving for each menu category. 2. The DFN added tray line checks to the department's QC Report beginning 3rd quarter 2008; these reports also go to the Operational PI Committee. 3. The dietitian reassesses patients on pureed diets at regular intervals to monitor the effectiveness of the nutritional plan of care and documents the information in the patient's medical record. In addition, the dietitian initiates a call to the patient's physician to discuss any significant concerns and to provide his/her recommendations. 4. To facilitate the patient's participation in the nutritional plan of care, the Diet Clerk seeks patient input during the 1:1 interviews that occur during the menu selection process. The Dietitian when rounding also seeks patient input. In addition, the DFN coordinates a patient satisfaction survey informally, using a hospital tool. An outside contractor also assesses patient satisfaction with dietary services as part of the hospital-wide patient satisfaction survey. 5. The DFN or FSM presents the results of tray line checks and satisfaction surveys at the unit-based staff meetings and is responsible for taking action to address identified opportunities for improvement.	07/17/08 07/17/08 & ongoing 08/01/08 & ongoing 08/01/08 & ongoing	
A 714	482.41(b)(7) FIRE CONTROL PLANS The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and	A 714		08/01/08 & ongoing	

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A 714	Continued From page 43 cooperation with fire fighting authorities. This STANDARD is not met as evidenced by: Based on observation, review of hospital documents and staff interview, the hospital failed to ensure there were updated written fire control plans in the kitchen at IVMC. The staff's lack of knowledge on the operation of the fire suppression system may have put both hospital personnel and patients at risk during a kitchen fire. Findings: During a tour of the kitchen at IVMC at approximately 3 p.m., on July 15, 2008, a new fire suppression system was observed. According to a tag attached to the system, the system was installed on July 3, 2008, approximately 12 days prior to the tour. Kitchen staff present during the tour, including the Director of Food and Nutrition (DFN) and Food Service Manager were interviewed on the operation of the new system. None of the staff interviewed was able to describe how the system operated. The posted instructions, including pictures posted underneath the system, did not match the new system. The posted instructions described a dry powder system, while the newly installed system was a wet chemical system. During an interview with the DFN on July 15, 2008, at approximately 3 p.m. the DFN stated she and her staff had not been trained on the operation of the system. The DFN stated she had requested information prior to the installation, but she had not been trained in the system's	A 714	CORRECTIVE ACTION: The Hospital took the following actions to assure that the fire control plans in the kitchen are current and the staff are knowledgeable in the operation of the fire suppression system: 1. The Director of Plant Operations (DPO) and the Food Service Manager (FSM) immediately educated the dietary staff members on duty at Inland Valley on the new kitchen hood fire suppression system. Education included verbal discussion of how the system worked to suppress a fire, how to activate the system, and steps to take post-discharge. The staff also received written instructional material. As additional staff members reported for work in the course of the days following, education was provided until all staff members were educated. 2. In anticipation of the installation of the hood at Rancho Springs campus, the DPO and FSM provided the same education to the dietary staff at Rancho Springs which included a review of how the system worked to suppress a fire, how to activate the system, steps to take post-discharge. They were also provided written instructional material. The hood system was installed on 07/24/2008. Post-installation, the FSM reiterated the instructional information with the dietary staff during department rounds. 3. The DPO prepared a written reference information handout based upon the information in the system's User's Manual. This was posted in the kitchen at Inland Valley and Rancho Springs. The reference provides step-by-step instructions, including diagrams, on how to activate the system.	07/17/08 07/24/08 07/31/08
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{A 747}	Continued From page 45 The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility failed to: 1. ensure the instruments in one of two sterile processing departments and one of two GI departments were cleaned in a manner to prevent the source and spread of infections. The surgical instruments were not cleaned according to facility policy and procedure. The solution concentrations were not correct for cleaning the surgical instruments and the endoscopes. (Refer to A 0748 Finding 1); 2. ensure cleaning solutions were left on surfaces for the amount of time recommended by the manufacturer at two of two facility campuses. This resulted in the potential for the spread of infectious diseases. (Refer to A0748 Finding 2); 3. ensure visitors of patients in isolation at two of two facility campuses were given instructions regarding isolation precautions. They also failed	{A 747}	SUMMARY OF CORRECTIVE ACTION DETAILED IN SUBSEQUENT TAGS: 1. The Directors of Infection Control and Perioperative services verified that the hospital policy contained the current guidelines recommended by the Association of periOperative Registered Nurses (AORN) to assure that instruments are cleaned in a manner to prevent the source and spread of infection. The SPD Tech observed during the survey was removed from duty by the Director of Perioperative Services, provided re-education, competency validation, and upon resuming duties, was job shadowed by the Lead SPD Tech to ensure compliance with proper cleaning procedures. (Please see response to A748 and A940.) 2. The Infection Control Director (ICD) provided clarification of expectations to all clinical areas during and immediately after the survey during July 2008 to assure that cleaning solutions were used in accordance with manufacturer's guidelines thus providing proper decontamination of surfaces. The ICD recommended investigation of other products to identify a solution with proper antimicrobial coverage that did not need to be in a wet state for 10 minutes. After proper approval, the ICD changed to a product that requires just 3 minutes for effective disinfection. (Please see response to A748.) 3. The ICD reviewed and reinforced the Isolation Precautions policy at the Charge Nurse meeting to clarify expectation that visitors are educated on isolation precautions and that patient care plans are up-to-date with appropriate documentation relating to isolation practices. (Please see response to A748.) 4. The ICD worked with the Director of	09/30/08 12/06/08 08/31/08 11/30/08	

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{A 747}	Continued From page 46 to ensure Patient care plans were up-to-date for four of eight patients reviewed who were on isolation precautions (Patients 701, 702, 707, and 704). This resulted in the potential for the spread of infections. (Refer to A0748 Finding 3); 4. ensure the operating room area in two of two facilities was maintained to prevent the source and spread of infections. A substerile room containing patient care supplies had wet encrusted towels around an open drain. An armrest had a tear/crack exposing the material beneath. (Refer to A0748 Finding 4), and; 5. ensure two of two facilities had a cleaning solution available for use that was effective against C-diff spores. This resulted in the potential for the spread of C-diff infections. (Refer to A0748 Finding 5) The cumulative effect of these systemic problems resulted in the facility's inability to provide quality care in a safe and sanitary environment to prevent the source and spread of infections. A 748 482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to: 1. ensure the instruments in one of two sterile processing departments and one of two GI	{A 747}	Perioperative Services and the Plant Operations Manager to address the findings of the dirty drain area in the sub sterile room and the finding of a torn armrest to assure that the ORs are maintained to prevent the source and spread of infection, (Please see responses to A748 and A940.) 5. The Hospital did and continues to use a product that is effective against C-diff vegetative forms as recommended by the CDC. The ICD and Environment Services (EVS) Manager educated the EVS staff members during morning report meetings and formally at the EVS staff meeting on the use of a dilute bleach solution when terminal cleaning an isolation room of a C-diff patient. The ICD enhanced the Isolation Room Cleaning policy to include terminal room cleaning with a 1:10 bleach/water solution which, according to the CDC, some investigators have recommended as effective against C-diff spores, that is an additional layer of precaution. (Please see response to A748.)	12/14/08	
		A 748	(1) CLEANING OF INSTRUMENTS: CORRECTIVE ACTION: a. Immediately after the surveyors identified a problem with how an SPD Tech was cleaning instruments and before the survey was over, the Infection Control Director (ICD) removed the SPD Tech from duty and had another SPD Tech reprocess all instruments according to Hospital policy. b. The ICD also immediately conducted an inservice with SPD personnel to review and	07/15/08 07/16/08	

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A 748	<p>Continued From page 49</p> <p>Cavicide pump bottle indicated the solution should be mixed in a concentration of 1 ounce per liter of water.) He then wiped the hoses with his gloved hands, rinsed the hoses off under running water, and wiped the hoses with a dry washcloth. The SPD Tech then used pressurized air on the hoses while holding them up in the air, causing a fine mist of liquid to come off the hoses and into the surrounding air, falling onto surrounding objects.</p> <p>The SPD Tech took a pre-mixed spray bottle of Cavicide and sprayed a mist on empty surgical procedure trays. He then immediately wiped the trays off. The directions on the spray bottle indicated the Cavicide was to stay wet on the surface at least 30 seconds.</p> <p>The SPD Tech then sprayed some Cavicide on a washcloth and wiped the top of a tray.</p> <p>During an interview with SPD Tech 2 on July 16, 2008, at 10:30 a.m., she stated the OR staff put a surgical towel on top of the unused instruments and then placed the used instruments on top of the towel. This procedure results in the potential for blood and other biomatter to drip down or drop down onto the "unused" instruments at the bottom of the procedure tray.</p> <p>During an interview with the Director of Perioperative Services on July 15, 2008, at 4:30 p.m., she stated all the instruments returning from an OR procedure should be soaked in the cleansing solution. She also stated the clamps and scissors should be opened so all surfaces were exposed to cleaning and disinfecting. She also stated the SPD tech should be following the directions for the use of the cleansing agents,</p>	A 748	<p>MONITORING:</p> <p>a. The SPD Lead and the ICD conducted real-time observations over the next month to validate that all SPD policies were being followed when instruments and other supplies were cleaned and processed.</p> <p>b. The SPD Lead and the ICD continue to monitor compliance through random real-time monitoring of SPD Techs while they perform cleaning processes. The ICD reports results/variances from this monitoring quarterly to the Infection Control Committee, which initiates performance improvement action planning as appropriate. The Infection Control Committee reports as indicated to the MEC, which reports as indicated to the Board of Governors at its bimonthly meetings.</p> <p>(2) CLEANING SOLUTIONS:</p> <p>CORRECTIVE ACTION:</p> <p>At the time of the survey, the Hospital used Sanicloth for surface cleaning and disinfection, which required the surface to be wiped and stay wet for 10 minutes; this time frame is challenging in times of high census. Therefore, the Hospital took the following actions:</p> <p>a. Immediately following the survey, the ICD provided information to all clinical managers and the environmental services manager regarding the Sanicloth product; expectations were clarified in that surfaces are to stay wet with the product for 10-minutes for effective disinfection. The ICD and unit managers took this same information to the staff during unit rounds.</p> <p>b. The ICD investigated other surface disinfecting products to determine if there was a product of appropriate efficacy that did not require such a lengthy time for effective</p>	<p>08/29/08</p> <p>09/01/08 & ongoing</p> <p>07/18/08</p> <p>07/21/08</p>
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A 748	<p>Continued From page 50 including making proper concentrations and leaving the surface wet for the amount of time recommended by the manufacturer. The Director stated the SPD Tech should not have been spraying hoses dry in such a manner as to cause a fine mist of liquid in the air.</p> <p>The policy and procedure titled "Cleaning and sterilizing equipment and supplies," dated April 2008, indicated in the section titled "decontamination," initial manual cleaning was to be done on all instruments. The policy and procedure also indicated solutions were to be mixed and used as recommended by the manufacturer. The policy and procedure did not have directions to the staff regarding how clamps and other instruments should be left open in order to expose all surfaces to cleaning.</p> <p>b. During a tour of the GI Lab on July 15, 2008, at 2 p.m., GI Tech 1 demonstrated how she cleaned the GI scopes. The Tech explained she put two "pumps," of the cleaner in each gallon of water. When measured, one pump was 20 cc's, which would be 40 cc's per gallon of water. The directions on the cleanser indicated the concentration was to be 30 cc's (1 ounce) per gallon.</p> <p>The facility policy and procedure for cleaning endoscopes indicated staff were to follow the manufacturer's directions for mixing cleansing solutions.</p> <p>2. During an interview with the Infection Control Director on July 14, 2008, at 10:15 a.m., the Director stated both campuses (RSMC & IVMC) use "PDI Sanicloth HB Germicidal Disposable Wipes," for cleaning equipment between patients.</p>	A 748	<p>disinfection. The ICD identified the Caviwipe product. This product requires 3 minutes for surface disinfection, a significant improvement over Sanicloth.</p> <p>c. At each new hire orientation, the ICD continued to educate the new employees on the use of Sanicloths for surface disinfection.</p> <p>e. The ICD presented information about cleaning agents at the Product Committee. Based upon comparative analysis of available products, the committee approved the ICD's recommendation to pursue Caviwipe.</p> <p>f. The ICD also took the information regarding Caviwipes to the Chair of the Infection Control Committee, an Infectious Disease specialist, for final approval.</p> <p>g. The ICD provided the ordering information for Caviwipes to the Director of Materials Management. The ICD worked with the Director of Education to plan staff inservices on the product.</p> <p>h. The Director of Education disseminated the staff education material. The vendor of the product was also on site to assist with staff education.</p> <p>i. The Caviwipe product was received and implemented.</p> <p>MONITORING:</p> <p>a. During the interim while the ICD was investigating possible replacement products, during Infection Control EVS routine rounding, members of Leadership directly observed staff using the Sanicloths to assure that they were following proper disinfection time.</p>	<p>08/2008 through 12/05/08</p> <p>09/19/08</p> <p>11/17/08</p> <p>11/17/08</p> <p>12/03/08</p> <p>12/05/08</p> <p>07/21/08 through 12/05/08</p>

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A 748	<p>Continued From page 51</p> <p>The directions on the container indicated the surface of the equipment must remain wet with the solution for at least 10 minutes.</p> <p>a. During a tour of the Radiology Department at RSMC, on July 14, 2008, at 11:35 a.m., CRT 1 was interviewed about how he cleaned equipment between patients. CRT 1 stated he used the "PDI Sanicloth HB Germicidal Disposable Wipes," and cleaned the equipment used by/for the patient. He stated if the solution was not dry in a minute or two he wiped it dry to get the equipment ready for the next patient.</p> <p>During an interview with RTS 1 on July 14, 2008, at 11:40 a.m., he stated when cleaning between patients he used the PDI Saniwipes on the equipment and then dried it off within a minute.</p> <p>b. During a tour of the Recovery Room at RSMC on July 14, 2008, at 2 p.m., RN 1 explained how they cleaned equipment between patients. RN 1 stated they used the PDI wipes to clean the equipment. RN 1 stated if the equipment dried prior to ten minutes she would not re-wet the equipment.</p> <p>c. During an interview at RSMC with RCP 1 on July 14, 2008, at 3:10 p.m., she described how she would clean a ventilator between patients. RCP 1 stated she used the PDI wipes on the outside of the ventilator and let it dry. She stated she did not time how long the surface was wet. She stated it stayed wet "a long time," but she was not able to say if it was at least ten minutes.</p> <p>d. During an observation of the Nuclear Medicine area at IVMC on July 15, 2008, at 1:20 p.m., and concurrent interview with CRT 2, he described</p>	A 748	<p>b. Unit-based leaders and Infection Control staff directly observe staff use of the Caviwipe to assure that staff are allowing the 3-minute surface disinfection time. Ongoing "on-the-spot" feedback is being provided to assure compliance with the product's manufacturer's guidelines.</p> <p>c. The ICD reports results/variances from this monitoring quarterly to the Infection Control Committee, which initiates performance improvement action planning and reports as appropriate to the MEC.</p> <p>d. Trends and variances, as indicated, are reported to the Board of Governors at its bimonthly meeting by either the MEC or the ADQO.</p> <p>(3) VISITORS & ISOLATION PRECAUTIONS: CORRECTIVE ACTION: To assure that visitors are educated regarding isolation practices and that the patient's care plan is up-to-date with appropriate entries related to isolation, the Hospital took the following actions:</p> <p>a. Immediately after the surveyors identified this issue and before the survey was over, the ICD spoke with the nurses caring for the identified patients to review this important aspect of care and the expectations as identified by hospital policy "Isolation Precautions". The visitors were provided with pertinent information relating to isolation practices, and the care plans were updated.</p> <p>b. Immediately after the survey, the ICD attended the hospital-wide Charge Nurses' Meeting to review the survey findings and discuss and reiterate the expectations as outlined in hospital policy relating to isolation practices that require visitor education and</p>	<p>12/06/08 & ongoing</p> <p>12/06/08 & ongoing</p> <p>12/06/08 & ongoing</p> <p>07/17/08</p> <p>07/18/08</p>

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A 748	Continued From page 52 how he would clean equipment between patients. He stated he would use the PDI wipes and demonstrated how he would clean. The area he cleaned dried within 15 seconds. He stated it usually dried that fast and that it is then ready for another patient. e. During an observation of the X-ray area at IVMC on July 15, 2008, from 1:25 to 1:50 p.m., CRT 3 was preparing the room between patients. CRT 3 removed pillows and a positioning block from the scanner bed. CRT 3 removed the linen from pillows and the scanner bed and placed them in a linen cart. CRT 3 then used the PDI wipes and wiped the scanner bed. He prepared a contrast dye in the injector pump, cleaned his hands with an alcohol-based gel and finished some paperwork. The surface of the scanner bed was dry within four minutes. After it dried CRT 3 placed a sheet on the scanner bed. CRT 3 did not wipe the pillows or the positioning block after they were used for the previous patient. During a concurrent interview with CRT 3 he stated the room was now ready for the next patient. 3a. During a tour of the ICU at RSMC on July 14, 2008, at 10:50 a.m., Patient 701 had a "contact precautions," sign on the door frame. The sign indicated gloves and gowns should be worn if there was going to be contact with the patient or the patient's environment. Visitors were observed in the room with Patient 701, holding the patient's hand and touching the bed and other items in the patient's environment. The visitors were not wearing gowns or gloves. During a concurrent interview with Patient 701's visitors, they stated they had not been instructed regarding the patient's isolation or need to wear protective equipment while in the room.	A 748	documentation in the patient's care plan and education record. c. The CNO and CEO reported the findings from the exit conference to the Board of Governors. d. The Nursing Managers discussed these issues with staff during unit rounds to assure that all nurses understood the expectations with respect to documenting precautions in care plans and educating families and visitors on isolation precautions. e. The ADQO provided followup reports on this issue to the Board of Governors. MONITORING: a. Infection Control staff conduct regular rounds on all patients in isolation. Incorporated into the rounding process is a review of the patient's chart for completeness of documentation (care plan and education forms). In addition, if there are visitors present during rounds, the Infection Control staff interview the visitors to confirm that they have been provided education relating to the patient's isolation status and the necessary precautions that apply. b. During the IC rounds, should the Infection Control staff identify any concerns, the IC staff give "on-the-spot" feedback, education, and clarification as appropriate. The IC staff provide feedback to the unit manager as appropriate. c. The ICD reports results/variances from this monitoring quarterly to the Infection Control Committee, which initiates performance improvement action planning and reports to the MEC as appropriate.	07/28/08 08/31/08 09/15/08 & 11/17/08 08/01/08 & ongoing 08/01/08 & ongoing 08/01/08 & ongoing	

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A 748	Continued From page 54 c. During a tour at IVMC on July 15, 2008, at 3:30 p.m., Patient 707 had a "Contact Precautions," sign on the door. The sign indicated gloves and gowns should be worn if there was going to be contact with the patient or the patients' environment. Family members for Patient 707 were in the room, holding the patient's hand and touching the bed and other items in the patient's environment. The visitors had gloves on but were not wearing gowns. During a concurrent interview with Patient 707's son, he stated the family had been told they were to wear gloves but were not given instructions about wearing gowns. During a concurrent interview with the Infection Control Director, he stated family and visitors should be instructed regarding isolation precautions when the patient they are visiting is in isolation. d. The admission paperwork, dated July 14, 2008, for Patient 704 was reviewed. Patient 704 was at IVMC with a diagnosis of MRSA. The Patient Care Plan, dated July 14, 2008, had an area titled "Precaution/isolation," which was left blank. During a concurrent interview with the Infection Control Director, he stated the care plans should be completed, including the areas regarding isolation precautions. 4a. During a tour of the OR at IVMC on July 15, 2008, at 2:30 p.m., there was a sub sterile room between ORs 1 and 2. The room had a flash sterilizer and an open door leading to a small storage area. In the storage area there was a warming cabinet containing warmed IV solutions and blankets. There was also an open shelf containing more patient care solutions (sterile water, IV fluids, Normal Saline, etc.). Approximately three feet across from the solutions and warming cabinet there was an open	A 748	d. The CNO and CEO reported the survey findings from the exit conference to the Board of Governors. e. Staff reviewed and discussed information related to the findings of the July survey at the Perioperative staff meetings. f. The ADQO reported the status of corrective action to the Board of Governors, along with more detail about the findings and individuals tasked with correction and response. g. The Plant Operations staff had the floor drain in the sub sterile room replaced. MONITORING: a. The OR Charge Nurse checks the sub sterile room daily and reports any identified concerns to Plant Operations for immediate correction. b. The ICD and the Plant Operations Manager also inspect the sub sterile room during normal monthly rounding. c. The ICD reports results/variances from this monitoring quarterly to the Infection Control Committee, which initiates performance improvement action planning and reports to the MEC as appropriate. d. The Board of Governors receives infection control reports bimonthly, as indicated, from either the MEC or the ADQO. (4.b) TORN ARMREST: CORRECTIVE ACTION: To assure that the Hospital maintains an environment that prevents the source and spread of infection, the following actions were taken:	07/28/08 08/21/08 09/15/08 & 11/17/08 11/30/08 07/21/08 & ongoing 07/21/08 & ongoing 07/21/08 & ongoing 07/21/08 & ongoing

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A 748	Continued From page 55 drain in the floor with water from the flash sterilizer emptying into the floor drain. Around the floor drain there were four surgical towels. The towels were wet with reddish brown rust-like stains and were encrusted with a white mineral-like substance. The floor around the drain had large reddish-brown rust like areas. b. During a tour of the RSMC OR on July 14, 2008, at 1:45 p.m., there was an operating room table armrest with a tear in the covering, exposing the material underneath. During a concurrent interview with the Director of Perioperative Services stated that, with the integrity of the arm rest impaired, the facility would not be able to ensure liquids and bodily fluids could not soak into the armrest and then contaminate the next patient. 5. During an interview with the Infection Control Director on July 14, 2008, at 10:15 a.m., he stated the two facilities (RSMC and IVMC) did not currently use a solution that is effective against C-diff spores. According to the CDC, (www.cdc.gov) C-diff spores can live for months on inanimate surfaces. The spores are not killed by most cleansing solutions and the only effective and therefore currently recommended solution for killing C-diff spores is a hypochlorite (bleach) solution or a cleanser containing an appropriate concentration of hypochlorite. A review of the infection control data and logs for both facilities for the past six months showed there were over 40 patients with a diagnosis of C-diff (and at times over 60 patients) admitted quarterly to the facility.	A 748	a. As soon as the surveyors identified the torn armrest during the survey, the Director of Perioperative Services immediately had the armrest with the partial tear removed from service and replaced with an armrest with a fully intact covering. b. To prevent a recurrence, the Director of Perioperative Services implemented the following process: (1) In the morning, prior to the first case, the circulator inspects each OR to confirm that all pad coverings are intact and without tears. (2) At the conclusion of each case, as the room is cleaned, the EVS staff member again visually inspects all pads for integrity. Should any pad have a tear, the EVS staff member notifies the Circulator, who is responsible for having the pad replaced prior to setting up for the next case. c. The CNO and CEO reported the survey findings from the exit conference to the Board of Governors. d. The staff member who orders supplies routinely checks the number of armrests to be sure there are two sets in stock. e. Information related to the findings of the July survey was reviewed and discussed at the Perioperative Board Rounds and Staff Meetings. f. The ADQO provided followup reports to the Board of Governors on the findings from the survey and the status of corrective action. MONITORING: a. The OR Managers and Charge RNs are responsible for overseeing the ongoing check of the integrity of the OR table pad and for making	07/14/08 07/18/08 07/28/08 08/01/08 & ongoing 08/22/08 09/15/08 & 11/17/08 08/01/08 & ongoing

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{A 748}	Continuation Page--	{A 748}	<p>concurrent observations to assure that the OR table pads have no tears that impair their integrity.</p> <p>b. The ICD also inspects the integrity of the OR table pads during routine rounds.</p> <p>c. The ICD reports results/variances from this monitoring quarterly to the Infection Control Committee, which initiates performance improvement action planning and reporting to the MEC as appropriate.</p> <p>d. Reports on infection control issues are provided bimonthly, as indicated, to the Board of Governors by either the MEC or the ADQO.</p> <p>(5) CLOSTRIDIUM DIFFICILE (C-DIFF):</p> <p>CORRECTIVE ACTION:</p> <p>a. The ICD and EVS Manager reviewed the CDC information on surface disinfectants.</p> <p>b. The ICD reviewed the policy on isolation precautions and confirmed that the information was consistent with current CDC recommendations for Contact Isolation. The ICD confirmed specifically that:</p> <p>(1) Hand hygiene is done exclusively by washing with soap and water; (2) Barrier protection is used (gowns, gloves); and (3) Daily room cleaning is done with an EPA-registered disinfectant.</p> <p>c. The ICD met with the EVS Manager to discuss terminal cleaning of isolation rooms and instructed the EVS Manager that when terminal cleaning of a patient room for C-Diff. is performed, the curtains are removed and all surfaces (including walls, floors, counters, etc.) are cleaned with a 1:10 solution of hypochlorite (bleach)/water.</p>	08/01/08 & ongoing 08/01/08 & ongoing 09/15/08 & ongoing 07/18/08 07/18/08 07/18/08	

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{A 748}	Continuation Page--	{A 748}	<p>d. The CNO and CEO presented findings from the exit conference to the Board of Governors.</p> <p>e. The ADQO provided updates to the Board of Governors on survey findings and corrective action.</p> <p>f. The ICD and EVS Manager provided education to the EVS staff on the use of dilute bleach solution for terminal cleaning of C-Diff. isolation rooms informally during morning report meetings in July 2008 and formally at the EVS staff meetings in August and September 2008.</p> <p>g. For completeness, the ICD revised the policy on isolation room cleaning to include the use of a 1:10 solution of hypochlorite (bleach)/water, which was offered "for consideration" in the CDC "Guideline for Disinfection and Sterilization in Healthcare Facilities." The policy revision includes supplemental procedures for cleaning of room occupied by a patient isolated with Clostridium Difficile. In the event a patient is isolated for Clostridium difficile an EPA registered hospital approved disinfectant must be used on a daily basis. When the patient is discharged, terminal cleaning of the room must be done with a 1:10 solution of hypochlorite (bleach)/water to include all surfaces.</p> <p>MONITORING:</p> <p>a. Infection Control staff and the EVS Managers conduct regular rounds for patients in isolation. Incorporated into the rounding process is the direct observation of how the rooms are cleaned during the patient's hospitalization and of the terminal cleaning process.</p> <p>b. If IC staff or EVS Managers identify a concern, "on-the-spot" feedback, education,</p>	07/28/08 09/15/08 & 11/17/08 09/30/08 12/14/08 08/01/08 & ongoing 08/01/08 & ongoing

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{A 748}	Continuation Page--	{A 748}	and clarification as appropriate are given to the staff member. c. The ICD reports results/variances of this monitoring quarterly to the Infection Control Committee, which initiates performance improvement action planning and reports to the MEC as appropriate. d. Either the MEC or the ADQO reports infection control issues to the Board of Governors at its bimonthly meeting. REBUTTAL: The Hospital respectfully submits that it was in compliance with Medicare rules with regard to C-Diff. The ICD and EVS Manager reviewed and confirmed that the Hospital has an effective program for preventing and limiting the spread of C-Diff in accordance with current recommendations of the CDC based on the following information: a. Reports indicate that C-Diff is on the rise nationally, but at the Rancho and Inland Valley campuses, the rate of hospital-acquired infection (HAI) with C-Diff is low and has been reduced further from 2007 to 2008. The Hospital HAI rate includes patients who developed C-Diff as a result of antibiotic therapy: 2007: --Overall C-Diff rate: 1.42/1000 patient days --HAI Rate: 0.52/1000 patient days. Through 3rd Quarter 2008: --Overall C-Diff Rate: 1.55/1000 patient days --HAI Rate: 0.27/1000 patient days, a 48% reduction from the previous year	08/01/08 & ongoing 08/01/08 & ongoing	

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{A 748 }	Continuation Page--	{A 748 }	<p>b. The ICD and EVS Manager confirmed that CDC notes that there are NO EPA-registered surface disinfectants with label claims for the inactivation of C-Diff spores. The CDC has reviewed some limited research studies that seem to indicate use of a hypochlorite-based germicide may lower incidence of C-Diff and noted this information on page 85 in its "Guidelines for Environmental Infection Control in Health-Care Facilities." In the CDC "Guidelines for Disinfection and Sterilization of Healthcare Facilities, 2008," the CDC states:</p> <p>—"Because no EPA-registered products exist that are specific for inactivating C. difficile spores, use of diluted hypochlorite SHOULD BE CONSIDERED in units with high C. difficile rates." (emphasis added)</p> <p>—"However, studies have shown that asymptomatic patients constitute an important reservoir within the health-care facility and that person-to-person transmission is the principal means of transmission between patients. Thus, combined use of hand washing, barrier protection, and meticulous environmental cleaning with an EPA-registered disinfectant should effectively prevent spread of the organism."</p> <p>The CDC further states in its information for Healthcare Providers, "Hospital cleaning products can be used for routine cleaning. Hypochlorite-based disinfectants have been used with some success for environmental surface disinfection in those patient-care areas where surveillance and epidemiology indicate ongoing transmission of C. difficile."</p> <p>Because the Hospital's rates of hospital-acquired C-Diff are actually decreasing, and because the program for cleaning was already consistent with CDC guidelines, the Hospital disagrees that it violated the Medicare rules.</p>	

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{A 940}	<p>482.51 SURGICAL SERVICES</p> <p>If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.</p> <p>This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility failed to</p> <ol style="list-style-type: none"> ensure the instruments in one of two sterile processing departments were cleaned in a manner to prevent the source and spread of infections. The surgical instruments were not cleaned according to facility policy and procedure, and; ensure the operating room area in two of two facilities was maintained to prevent the source and spread of infections. A sub sterile room containing patient care supplies had wet encrusted towels around an open drain. An armrest had a tear/crack exposing the material beneath. <p>The cumulative effect of these systemic problems resulted in the facility's inability to provide safe surgical care in accordance with acceptable standards of practice.</p> <p>Findings:</p> <ol style="list-style-type: none"> A tour of the sterile processing department at IVMC was conducted on July 15, 2008. SPD 	{A 940}	<p>(1) CLEANING OF INSTRUMENTS:</p> <p>CORRECTIVE ACTION:</p> <ol style="list-style-type: none"> Immediately after the surveyors identified a problem with how an SPD Tech was cleaning instruments and before the survey was over, the Infection Control Director (ICD) removed the SPD Tech from duty and had another SPD Tech reprocess all instruments according to Hospital policy. The ICD also immediately conducted an inservice with SPD personnel to review and reinforce all process and solution measurements according to Hospital policy. This included complying with the proper process when handling instruments and following the manufacturer's directions for the concentration of cleaning solutions. Following the conclusion of the survey, the Directors of Infection Control and Perioperative Services reviewed the Hospital policy, "Cleaning and Sterilizing Equipment and Supplies" in light of the most current recommendations and guidelines of the Association of periOperative Registered Nurses (AORN) and the Association for the Advancement of Medical Instrumentation (AAMI) as they relate to the proper cleaning of instruments, and added a clarifying statement to read, "Instruments not grossly soiled will be individually unlocked and inspected for dirt, soil, bioburden, or any foreign material prior to being placed in the ultrasonic and/or washer disinfectant." The Directors also verified that the policy directed that employees are to follow the manufacturer's guidelines when using cleaning agents. The P&P Committee approved the revision to the policy. 	07/15/08	07/16/08	07/22/08

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{A 940}	Continued From page 57 Tech 1 was observed from 2:35 p.m. to 3:10 p.m. cleaning, disinfecting, and prepping surgical instruments that had been used in a surgical procedure. The SPD Tech removed, from a procedure tray, instruments that he assumed had been directly used in a surgical procedure and placed them in a cleansing solution. The SPD Tech left instruments he assumed were not directly used in a surgical procedure in the bottom of the procedure tray. The instruments left in the bottom of the procedure tray included a set of at least 15 to 20 clamps/scissors that were bunched together with a longer set of clamps inserted through the handle to hold the set together. The clamps and scissors were closed and the interior surfaces were not exposed. The SPD Tech scrubbed and washed the instruments he soaked in the cleansing solution and then placed them on top of the instruments he left in the procedure tray. The SPD Tech did not soak the instruments left in the procedure tray, open the instruments to expose all surfaces, nor did he closely inspect those instruments he assumed were not soiled with biomatter. During a concurrent interview on July 15, 2008, at 3 p.m., the SPD Tech stated he does not put all instruments in the cleansing solution and scrub them. He stated he only puts them in the solutions and scrubs them if he sees biomatter on the outside of the instruments. To clean the air hoses and other flexible hosing, the SPD Tech squirted full-strength Cavicide (a cleaning agent used for cleaning the surgical instruments) from the pump bottle directly on the hoses. (The directions on the full-strength Cavicide pump bottle indicated the solution should be mixed in a concentration of one ounce	{A 940}	d. The Directors reviewed the policy with the Perioperative Leadership team to assure that all had a clear understanding of the policy and of the expectations that the Leads provide oversight by monitoring all SPD Techs, validating on an ongoing basis that the cleaning process is consistent with Hospital policy. e. The ICD re-educated the SPD Tech who had been removed from duty. The education included a review of hospital policy concerning cleaning and sterilizing equipment and supplies, proper cleaning of all instruments on the tray, use of solvent and use of the pressurized air hose when cleaning tubing. The SPD tech completed a competency evaluation to confirm understanding of all requirements prior to resuming duties. f. The CNO and CEO reported the preliminary findings from the exit conference to the Board of Governors. g. Once the SPD Tech successfully completed the competency evaluation, the ICD/designee monitored the SPD Tech via job shadowing with concurrent observation for one week, to be sure that the SPD Tech was complying with Hospital policy for the proper cleaning of instruments. h. The SPD Leads directly observed all techs to confirm that each employee followed Hospital policy and that all steps in the instrument cleaning process were completed properly. i. The ADQO provided a followup report to the Board of Governors. j. The ICD reviewed information related to the findings of the July survey and provided ongoing updates at Perioperative Board Rounds and Staff Meetings.	07/22/08 07/25/08 07/28/08 08/01/08 08/04/08 09/15/08 09/30/08	

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{A 940}	<p>Continued From page 58</p> <p>per liter of water.) He then wiped the hoses with his gloved hands, rinsed the hoses off under running water, and wiped the hoses with a dry washcloth. The SPD Tech then used pressurized air on the hoses while holding them up in the air, causing a fine mist of liquid to come off the hoses and into the surrounding air, falling onto surrounding objects.</p> <p>The SPD Tech took a pre-mixed spray bottle of Cavicide and sprayed a mist on empty surgical procedure trays. He then immediately wiped the trays off. The directions on the spray bottle indicated the Cavicide was to stay wet on the surface at least 30 seconds.</p> <p>The SPD Tech then sprayed some Cavicide on a washcloth and wiped the top of a tray.</p> <p>During an interview with SPD Tech 2 on July 16, 2008, at 10:30 a.m., she stated that the OR staff puts a surgical towel on top of the unused instruments and then places the used instruments on top of the towel. This procedure results in the potential for blood and other biomatter to drip down or drop down onto the "unused," instruments at the bottom of the procedure tray.</p> <p>During an interview with the Director of Perioperative Services on July 15, 2008, at 4:30 p.m., the Director stated all the instruments returning from an OR procedure should be soaked in the cleansing solution. She also stated the clamps and scissors should be opened so that all surfaces were exposed to cleaning and disinfecting. The Director also stated the SPD tech should be following the directions for the use of the cleansing agents, including making proper concentrations and leaving the surface wet for the</p>	{A 940}	<p>k. The ADQO provided more detailed report to the Board of Governors following receipt of the official CMS 2567, and the Board of Governors concurred with the plan for responding and directed that an ongoing update on these issues be provided at future Board meetings.</p> <p>MONITORING:</p> <p>a. The SPD Lead and the ICD conducted real-time observations over the next month to validate that all SPD policies were being followed when instruments and other supplies were cleaned and processed.</p> <p>b. The SPD Lead and the ICD continue to monitor compliance through random real-time monitoring of SPD Techs while they perform cleaning processes. The ICD reports results/variances from this monitoring quarterly to the Infection Control Committee, which initiates performance improvement action planning as appropriate. The Infection Control Committee reports as indicated to the MEC, which reports as indicated to the Board of Governors at its bimonthly meetings.</p> <p>(2.a.) SUB STERILE ROOM:</p> <p>CORRECTIVE ACTION:</p> <p>To assure that the Hospital maintains an environment that prevents the source and spread of infection, the following actions were taken to address the findings in the sub-sterile room at the Inland Valley campus:</p> <p>a. Immediately after the survey, the ICD and Director of Perioperative Services inspected the sub sterile room with the Plant Operations Manager. They confirmed that the IV solutions were sealed and in an enclosed cabinet; the blanket warmer had an adequate seal due to the</p>	11/17/08 08/29/08 09/01/08 & ongoing 07/18/08

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{A 940}	Continued From page 59 amount of time recommended by the manufacturer. She stated the SPD Tech should not have been spraying hoses dry in such a manner as to cause a fine mist of liquid in the air. The policy and procedure titled "Cleaning and sterilizing equipment and supplies" dated April 2008, indicated in the section titled "decontamination," that initial manual cleaning was to be done on all instruments. The policy and procedure also indicated solutions were to be mixed and used as recommended by the manufacturer. The policy and procedure did not have directions to the staff regarding how clamps and other instruments should be left open in order to expose all surfaces to cleaning. 2. a. During a tour of the OR at IVMC on July 15, 2008, at 2:30 p.m., there was a sub sterile room between ORs 1 and 2. The room had a flash sterilizer and an open door leading to a small storage area. In the storage area there was a warming cabinet containing warmed IV solutions and blankets. There was also an open shelf containing more patient care solutions (sterile water, IV fluids, Normal Saline, etc.). Approximately three feet across from the solutions and warming cabinet there was an open drain in the floor with water from the flash sterilizer emptying into the floor drain. Around the floor drain there were four surgical towels. The towels were wet with reddish brown rust-like stains and were encrusted with a white mineral-like substance. The floor around the drain had large reddish-brown rust like areas. b. During a tour of the RSMC OR on July 14, 2008, at 1:45 p.m., there was an operating room table armrest with a tear in the covering exposing	{A 940}	door seal protecting the contents; the open storage rack in the alcove contained only supplies that are impervious to moisture and unaffected should there be temperature changes associated when the door of the sterilizer is opened; and the door to the sterilizer opened out and away from the storage alcove to better disperse the steam. b. The Plant Operations staff removed the dirty towels surrounding the drain and thoroughly cleaned the area. The ICD then inspected the area for cleanliness and instructed staff members not to place any material, such as towels, about the drain. c. The Plant Operations staff checked the functioning of the drain to confirm that there were no restrictions that might prevent adequate draining of water from the normal functioning of the sterilizer. They determined that the drain functioned appropriately, but recommended that the drain be replaced prior to the end of the year to prevent any future problems. d. The CNO and CEO reported the survey findings from the exit conference to the Board of Governors. e. Staff reviewed and discussed information related to the findings of the July survey at the Perioperative staff meetings. f. The ADQO reported the status of corrective action to the Board of Governors, along with more detail about the findings and individuals tasked with correction and response. g. The Plant Operations staff had the floor drain in the sub sterile room replaced.	07/18/08 07/18/08 07/28/08 08/21/08 09/15/08 & 11/17/08 11/30/08	

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{A 940}	Continuation Page--	{A 940}	<p>MONITORING:</p> <p>a. The OR Charge Nurse checks the sub sterile room daily and reports any identified concerns to Plant Operations for immediate correction.</p> <p>b. The ICD and the Plant Operations Manager also inspect the sub sterile room during normal monthly rounding.</p> <p>c. The ICD reports results/variances from this monitoring quarterly to the Infection Control Committee, which initiates performance improvement action planning and reports to the MEC as appropriate.</p> <p>d. The Board of Governors receives infection control reports bimonthly, as indicated, from either the MEC or the ADQO.</p> <p>(2.b) TORN ARMREST:</p> <p>CORRECTIVE ACTION:</p> <p>To assure that the Hospital maintains an environment that prevents the source and spread of infection, the following actions were taken:</p> <p>a. As soon as the surveyors identified the torn armrest during the survey, the Director of Perioperative Services immediately had the armrest with the partial tear removed from service and replaced with an armrest with a fully intact covering.</p> <p>b. To prevent a recurrence, the Director of Perioperative Services implemented the following process:</p> <p>(1) In the morning, prior to the first case, the circulator inspects each OR to confirm that all pad coverings are intact and without tears.</p>	<p>07/21/08 & ongoing</p> <p>07/21/08 & ongoing</p> <p>07/21/08 & ongoing</p> <p>07/21/08 & ongoing</p> <p>07/14/08</p> <p>07/18/08</p>	

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{A 940}	Continuation Page--	{A 940}	<p>(2) At the conclusion of each case, as the room is cleaned, the EVS staff member again visually inspects all pads for integrity. Should any pad have a tear, the EVS staff member notifies the Circulator, who is responsible for having the pad replaced prior to setting up for the next case.</p> <p>c. The CNO and CEO reported the survey findings from the exit conference to the Board of Governors.</p> <p>d. The staff member who orders supplies routinely checks the number of armrests to be sure there are two sets in stock.</p> <p>e. Information related to the findings of the July survey was reviewed and discussed at the Perioperative Board Rounds and Staff Meetings.</p> <p>f. The ADQO provided followup reports to the Board of Governors on the findings from the survey and the status of corrective action.</p> <p>MONITORING:</p> <p>a. The OR Managers and Charge RNs are responsible for overseeing the ongoing check of the integrity of the OR table pad and for making concurrent observations to assure that the OR table pads have no tears that impair their integrity.</p> <p>b. The ICD also inspects the integrity of the OR table pads during routine rounds.</p> <p>c. The ICD reports results/variances from this monitoring quarterly to the Infection Control Committee, which initiates performance improvement action planning and reporting to the MEC as appropriate.</p> <p>d. Reports on infection control issues are provided bimonthly, as indicated, to the Board of Governors by either the MEC or the ADQO.</p>	07/28/08 08/01/08 & ongoing 08/22/08 09/15/08 & 11/17/08 08/01/08 & ongoing 08/01/08 & ongoing 08/01/08 & ongoing 09/15/08 & ongoing	

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{A 940}	Continued From page 60	{A 940}			
{A1004}	<p>the material underneath. During a concurrent interview with the Director of Perioperative Services she stated that, with the integrity of the arm rest impaired, the facility would not be able to ensure liquids and bodily fluids could not soak into the armrest and contaminate the next patient.</p> <p>482.52(b)(3) INPATIENT POST-ANESTHESIA EVALUATION</p> <p>With respect to inpatients, a post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia as specified in paragraph (a) of this section within 48 hours after surgery.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to ensure the post-anesthesia assessment documented by the anesthesiologist was complete and followed accepted practice guidelines. Three surgical patient records were reviewed at the Southern campus on July 16, 2008, at 9 a.m., (Patients 116, 117, 118). None of these had a complete post-anesthesia assessment documented. Three surgical charts were reviewed at the Northern campus. Two patients (Patients 108 and 109) had a subset of the recommended elements. One patient (Patient 110) did not have a complete post-anesthesia assessment. This resulted in potential for changes in patient condition to be unrecognized. Other caregivers would be unable to review the post-anesthesia note to see what the patients' condition was after anesthesia.</p>	{A1004}	<p>CORRECTIVE ACTION:</p> <p>To assure that the post-anesthesia assessment documented by the physician is complete the following actions were taken:</p> <p>The Chair of Anesthesia reviewed the Anesthesia Record (SW126) and Anesthesia Evaluation (SW124) forms with the Director of PI (DPI). The Anesthesia Chair validated that the forms themselves contained the proper components of a post-anesthesia evaluation as recommended by The Joint Commission, Title XXII, and ASA guidelines.</p> <p>The Chair of Anesthesia reviewed the requirements of a complete post-anesthesia evaluation as stated by CMS, The Joint Commission, Title XXII, and the recommendations in the ASA guidelines at the Department of Anesthesia meeting and reminded Department members to complete the post-anesthesia sections of the forms currently in use.</p> <p>MONITORING:</p> <p>The Health Information Management (HIM) Department is responsible for analyzing the patient's chart for the completeness of the medical record. If the post-anesthesia assessment is not complete, the HIM</p>	08/04/08 09/11/08 10/01/08 & ongoing	

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{A1004}	<p>Continued From page 61</p> <p>Findings:</p> <p>The interpretative guidelines for the regulation recommend that the post-anesthesia note contain the information suggested by a nationally accepted source. The Practice Guidelines for post-anesthetic care published in the journal, Anesthesiology, contains the recommendations of the American Society of Anesthesiologists. These guidelines suggest that the Post-anesthesia assessment include:</p> <ul style="list-style-type: none"> Respiratory Function, including respiratory rate, airway patency and oxygen saturation; Cardiovascular function, including pulse rate and blood pressure; Mental status; Temperature; Pain; Nausea and vomiting; and Postoperative hydration. <p>The record of Patient 108 was reviewed on July 15, 2008. The record contained two forms in which the anesthesiologist recorded post-anesthesia data. The first is a small box on the anesthesia record labeled Recovery Room. There was a place to document blood pressure, pulse, respiratory rate and temperature as well as oxygen saturation and mental status. There was no area to document pain or hydration. Patient 108's post anesthesia data contained only the patient's blood pressure and temperature. The second place where this information may be documented was on the Pre-anesthesia Assessment Form. The bottom of this form contained an area labeled post-anesthesia assessment and several lines for free text. The only writing in this section for Patient 108 was "no apparent anesthesia complications."</p>	{A1004}	<p>Analyst flags the anesthesiologist. The anesthesiologist is required to complete the assessment.</p> <p>Physicians who do not complete the medical record in the required time frame are placed on suspension until the delinquent records are completed. Medical records suspensions are one of the elements evaluated during the physician's reappointment process.</p>	10/01/08 & ongoing	

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{A1004}	Continued From page 62 The records for Patients 109 and 110 were reviewed on July 16, 2008. The records contained minimal information on the post-anesthesia assessment, but did contain most of the recommended elements on the anesthesia record. The records for Patients 116, 117 and 118 were reviewed on July 16, 2008. The records contained minimal information on the post-anesthesia assessment and also did not have the recovery room section of the anesthesia record completed.	{A1004}			