

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

PRINTED: 03/30/2009
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 03/05/2009
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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 second revisit following a Full Certification Survey authorized by the Centers for Medicare and Medicaid Services, Region IX, conducted March 2 through March 5, 2009.</p> <p>Representing the Department of Public Health: Tina Buchanan, HFEN Omar Fausto, HFEN Jennifer Hoke, RN, IC Consultant</p> <p>Abbreviations used in this document:</p> <p>AORN - Association of Operating Room Nurses CNA - Certified Nursing Assistant COO - Chief Operating Officer IC - Infection Control IOR - Inspector of Record IP - Infection Preventionist IVMC - Inland Valley Medical Center MRSA - Methicillin Resistant Staphylococcus Aureus OR - Operating Room PCU - Progressive Care Unit PPE - Personal Protective Equipment PT - Physical Therapist RN - Registered Nurse RNFA - Registered Nurse First Assist RSMC - Rancho Springs Medical Center RT - Radiology Technologist Surg - Surgical Tech - Technician Tele - Telemetry w/o - Without</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 MAY -7 AM 3:53</p> <p>INVESTIG & CERT. RIVERSIDE COUNTY</p> <p>DEPT OF PUBLIC HEALTH</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE CEO	(X6) DATE 5.6.09
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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

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(A 000)	Continued From Page 1	(A 000)	Continued from Page 1	
(A 043)	<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> <ol style="list-style-type: none"> ensure a safe environment for 11 of 11 patients in the PCU by failing to have a nurse call system in the PCU nurse's station, resulting in a potential for delay in care (A144); ensure the visitor of one patient in contact isolation (Patient 313) followed appropriate isolation precautions, resulting in the potential for MRSA to spread to the visitor, patients, and staff (A749); ensure facility staff followed transmission-based precautions when caring for two patients in contact isolation (Patients 313 and 314), resulting in the potential for MRSA to spread to patients and staff (A749); develop, implement, and maintain a process to ensure the adequate cleaning and use of re-useable headgear in the ORs and other restricted and semi-restricted areas, resulting in the potential for infections to start in surgical patients and spread throughout both hospital campuses (A749) (A951); and, 	(A 043)	<p>Governing Body Actions Taken</p> <ol style="list-style-type: none"> The Board Chair and CEO were present at the exit conference on behalf of the Board to hear the outcome of the Survey. The Chair specifically told the surveyors she is confident that the Hospital will fully meet and comply with the State requirements regarding use and conversion of space. The Chair also stated that the opening of the new building at the Rancho Springs campus will significantly enhance patient care and safety by providing much needed space, which was the key concern mentioned. The Board Chair confers on a weekly basis (either on-site or via phone) with the CEO regarding the hospital's corrective actions related to achieving and maintaining compliance with Medicare Conditions of Participation. The CEO as a Board member updates the full Board at least monthly, and more frequently when survey updates and information become available. The CEO and Board Chair reported to the Board of Governors on 03/17/09 concerning the survey results and the actions being taken to achieve compliance. The Board members discussed at length detailed findings that were identified during the survey and actions that were being taken to address the concerns identified by the survey team. The Board expressed its support for the plan and directed that the hospital staff take the following actions: <ol style="list-style-type: none"> PCU Nurses Station: The Board concurred with the Chief Nursing Officer's (CNO) actions taken on 03/05/09 to immediately discontinue the use of Rm #267 as a nurses' station for the PCU. The Board directed the hospital leadership: 1) to take the appropriate steps to effectively convert the space for the use as a PCU Nurses Station, and 2) not to use Rm #267 as a nurses' station until the hospital receives written approval from the State. Visitors to Isolation Rooms: The Board tasked the Administrative Director of Quality Outcomes (ADQO) and the Infection Control (IC) Director to review the isolation precautions policy to determine if the policy requires revision and if so, to initiate the proper steps to effectively comply with current CDC guidelines for visitors to patients in isolation. Staff Compliance with Transmission-Based Precautions: The Board was notified of the actions taken regarding specific individuals observed during 	<p>03/05/09</p> <p>03/05/09 and ongoing</p> <p>03/17/09 and ongoing</p>

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{A 043}	Continued From Page 2a 5. ensure facility staff followed manufacturer's recommendations for disinfectant use in one of two ORs and one of one newborn nurseries, resulting in the potential for infections to start in surgical patients and newborn babies and spread throughout the RSMC campus (A749) (A951). The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the provision of quality health care in a safe and effective manner.	{A 043}	Continued from Page 2a Monitoring In order to assess the effectiveness of this plan of correction, the Board directed the CEO and the ADQO to provide a regular report on survey status, actions taken, and monitoring for compliance at each bi-monthly Board meeting for the Board's discussion and recommendations.	03/07/09 and ongoing
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This Standard is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a safe environment for 11 of 11 patients in the PCU by failing to have a nurse call system in the PCU nurses' station, resulting in a potential for delay in care. Findings: 1. During a tour of the PCU at IVMC on March 2, 2009, at 9:35 a.m., patient room 267 was observed being used as a nurses' station. The room contained two desks with computers, a chart rack with PCU patient charts, papers used for charting, telephones, and office supplies.	A 144	CARE IN A SAFE SETTING - PCU Nurses' Station Actions Taken 1. The CNO directed that the use of Room #267 as a Nurses' Station be immediately discontinued. The two desks, computers and miscellaneous supplies were removed. The room was empty and available for patient use by 8:00pm on 03/05/09. The PCU nurses moved back to, and are currently using the 2W Nurses' Station (the approved nursing station for 2W) until the additional changes are made and approved. 2. The Plant Operations Manager (POM) met with the OSHPD Area Compliance Officer (ACO) and reviewed the OSHPD Plans to confirm that the plans were satisfactory. This additional nursing station is being added so that the PCU nurses can be closer to the PCU patients under their care. The close proximity to the patient rooms allows for close observation and more rapid nursing response. The plans include connection to the nurse call system and installation of a sink with unrestricted access. The changes were deemed appropriate for temporary conversion of space. The Inspector of Record was notified and work began. 3. The hospital submitted a written request for the temporary conversion of space to CaDPH. The request included a copy of the OSHPD approved plans. 4. Room #267 will remain available for patient use until such time as CaDPH reviews and provides written approval for the space conversion, as requested by the hospital.	03/05/09 03/24/09 03/30/09 03/30/09

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A 144	<p>Continued From Page 3</p> <p>The room did not have a nurse call system so the patients could summon their nurse directly when they had a need. The current census in the PCU was 11 patients.</p> <p>Not having a nurse call system in the station meant the patients had to call a different nurses' station to request assistance. The staff at that station had to locate a PCU nurse to respond to the PCU patient. If the PCU nurses did not answer the phone at their station, the staff at the station the patient called would have to page the PCU nurse. There was no system in place to ensure the PCU nurse received and answered their page, with a potential for delay in care.</p> <p>During an interview with the Manager of Plant Operations on March 2, 2009, at 9:50 a.m., the manager stated he had ordered the parts for a nurse call system, and he would install them when they arrived. The manager stated the tele tech at the main nurses' station (located down the hall and around the corner) answered the PCU call lights, and they called the PCU nurses when the PCU patients requested a nurse.</p> <p>During an interview with the tele tech on March 2, 2009, at 9:53 a.m., the tech stated when a PCU call light went off, she would call the PCU nurses' station to get a PCU nurse to respond to the light. The tech stated the PCU nurses carried pagers in case they were not at the nurses' station to answer the phone, but she did not know their pager numbers or how to use the paging system.</p> <p>During an interview with the Manager of Plant Operations on March 2, 2009, at 11:50 a.m., the manager stated he did not know room 267 was converted to a nurses' station at the time of the conversion. The manager stated he identified</p>	A 144	<p>Continued from Page 3</p> <p>5. Upon completion of the work identified in the plans, the room was inspected and verbally signed-off by local fire and OSHPD.</p> <p>6. On 04/21/09, the ADQO forwarded the OSHPD Certificate of Occupancy to the State and is currently awaiting written approval from CaDPH for the space conversion.</p> <p>Ongoing Compliance with Space Conversion Requirements The hospital clarified and revised the process relating to use of space as follows:</p> <ol style="list-style-type: none"> 1. The Chief Operating Officer (COO), or designee, is responsible for all "space" within the hospital buildings. Any Leadership member who requests space or wishes to convert space for another purpose must obtain approval from the COO. The POM is also responsible for monitoring the use of space during routine rounding through the buildings. 2. During project planning, the POM and COO work together to assure that appropriate OSHPD plan approval and CaDPH approval are obtained prior to using converted space. 3. The COO is responsible for submitting an approval request to CaDPH for any proposed conversion of space from its previously approved purposes. The hospital will not change the actual use of that space until written approval by CaDPH has been received. 4. During the Operational PI Committee, the COO reviewed with key administrative staff and department heads the revised process concerning space conversion and the need to obtain both OSHPD and CaDPH approval prior to converting space to a different use. 5. The Administrative Director of Quality Outcomes (ADQO) drafted a template form to be used by the COO (or designee) to submit a request for either permanent or temporary conversion of space to CaDPH. 6. The Executive Administrative Coordinator assists the COO in maintaining a tracking system for the requests to convert space. 7. Upon receiving written approval from CaDPH regarding a temporary or permanent conversion of space, the COO (or designee) is responsible for authorizing the change in use. <p>Person Responsible: Chief Operating Officer</p>	<p>04/03/09</p> <p>04/21/09</p> <p>03/06/09 and ongoing</p> <p>03/06/09 and ongoing</p> <p>03/06/09 and ongoing</p> <p>03/10/09</p> <p>03/24/09</p> <p>03/24/09 and ongoing</p> <p>03/24/09 and ongoing</p>

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A 144 Continued From Page 4

the conversion during rounds with the IOR approximately one month after the change was made. The manager stated he knew a nurse call system was required, but he was not involved in planning the conversion.

The nurse's station building plan documents were reviewed on March 2, 2009. The documents indicated the COO was notified a nurse call system was not in the nurses' station on October 15, 2008 (four and one half months prior to the date of the survey).

Although the facility was aware of the patient safety risks with no nurse call system in the PCU nurses' station, the facility continued to use the room as a nurses' station through the exit date of the survey, March 5, 2009, for four and one half months after they were told it needed a nurse call system.

{A 747} 482.42 INFECTION CONTROL

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

A 144 Continued from Page 4

Monitoring:

1. The POM monitors the use of space during routine rounding through the building. Should the POM identify a concern regarding the appropriate use of space, the POM contacts the COO, and if the concern is substantiated, they work together to return the space to its approved use and obtain approvals..
2. The COO oversees the use of space in the facilities of SWHCS, coordinates any requests for space or change of use, and ensures the proper OSHPD and CaDPH approval process is complete prior to authorizing space conversion for use. The COO also conducts periodic rounding to monitor the use of space within the Hospitals.

Background Information - The hospital had been working with the OSHPD ACO over the course of the past few months to address the OSHPD requirements to add this as an ADDITIONAL space on 2W so that PCU nurses could be based closer to the 9 PCU beds. Plans were drafted and approved on 2/23/2009, prior to the onsite survey of March 5, 2009, to convert the space temporarily to a nurses' station. But throughout this time, the main nurses' station on 2W continued to function, and the PCU nurses immediately returned to the main nurses' station by the end of the day on 3/5/09.

{A 747}

Tag A747 - Infection Control

Global Actions Taken by Leadership related to Infection Prevention Practices

1. The CEO convened Joint Leadership (Senior Administrators and Directors) to debrief following the Exit Conference to relay all concerns identified by the survey team. The CEO stressed leadership's role in establishing expectations, observing staff behaviors, and holding all accountable for complying with appropriate infection prevention practices, including isolation precautions and cleaning requirements.
2. The ADQO worked with a leadership task group to establish a new program, Building Excellent Service Together (BEST), to promote a Culture of Safety and establish Rounding for Excellence by having key administrative staff and department heads/managers perform rounds to oversee employees and promote excellence. The task group

03/06/09 and ongoing

03/06/09 and ongoing

03/05/09

03/19/09 and ongoing

09 MAY - 7 AM 3:53
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(A 747)	Continued From Page 5 review, the facility failed to: 1. provide handwashing facilities in the PCU nurses' station (an unapproved patient room conversion) at the IVMC campus, resulting in the potential for infections to spread among patients cared for in the PCU (A022); 2. ensure the visitor of one patient in contact isolation (Patient 313) followed appropriate isolation precautions, resulting in the potential for MRSA to spread to the visitor, patients, and staff (A749); 3. ensure facility staff followed transmission-based precautions when caring for two patients in contact isolation (Patients 313 and 314), resulting in the potential for MRSA to spread to patients and staff (A749); 4. develop, implement, and maintain a process to ensure the adequate cleaning and use of re-useable headgear in the ORs and other restricted and semi-restricted areas, resulting in the potential for infections to start in surgical patients and spread throughout both hospital campuses (A749) (A951); and, 5. ensure facility staff followed manufacturer's recommendations for disinfectant use in one of two ORs and one of one newborn nurseries, resulting in the potential for infections to start in surgical patients and newborn babies and spread throughout the RSMC campus (A749) (A951). The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the provision of quality health care in a safe and sanitary environment.	(A 747)	Continued from Page 5 was named the BEST Council which met to identify, prioritize, and take action to correct issues or concerns identified in the survey and through the rounds. The ADQO chairs the BEST Council, and the IC Director is a standing member to provide subject matter expertise concerning infection prevention and control. 3. The BEST Council formed rounding teams and established a weekly rounding schedule. The BEST Council disseminated information on the rounding program all employees through unit discussions, flyers, and information in the Hospital newsletter called the Daily Line Up. The rounds began the week of 3/30/2009. 4. The CEO and ADQO disseminated information on the principals of infection prevention (hand hygiene, isolation precautions and surface cleaners) to all employees. This was done via open forum Town Hall meetings during all shifts on 03/24/06 and 03/26/09 and by attaching the information to all employee paychecks on 04/03/09. 5. The CEO authorized the retention of a consulting firm that specializes in regulatory compliance. The Infection Control Consultant provided education to hospital Leadership, policy review and evaluation based on unit rounding. 6. The Infection Control Committee Chair conducted the meeting of Medical Staff Policy & Procedure Committee that reviewed and revised the Isolation Precautions policy regarding: a. Transmission-based precautions and required personal protective equipment. b. Actions to take if a visitor does not comply with appropriate precautions. 7. The MEC approved the revised Isolation Precautions policy. 8. The IC Director provided a FAQ handout to Managers and Directors as an employee reference related to infection control practices (isolation basics, hand hygiene and surface cleaners). For those employees that provide direct patient care, the Managers completed staff education on isolation precautions. Managers are responsible for tracking which employees missed the education because of an infrequent work schedule or a leave of absence, and for being sure such an employee receives the education upon the employee's return to work. 9. Responding to feedback from front-line care providers, the senior administrative team, including the IC Director and the Chief of Staff, further clarified the Isolation Precautions policy to require consistent use of the applicable personal protective equipment by	03/30/09 and ongoing 04/03/09 04/03/09 04/15/09 04/16/09 04/25/09 and ongoing 05/04/09

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(A 747)	Continued From Page 6	(A 747)	<p>Continued from Page 6</p> <p>all who enter an isolation room, specific to the category of precautions in effect. The CEO and the Chief of Staff approved the policy on 05/01/09, and the ADQO distributed the revised policy to clinical managers, who provided the updated information to direct care givers via a quick reference badge card. The IC Director revised and then distributed door signs regarding isolation precautions to all inpatient nursing units. Persons Responsible: CEO, ADQO, IC Director and Managers.</p> <p>Monitoring:</p> <ol style="list-style-type: none"> 1. The ADQO reviews the staff education reports for completeness and addresses any concerns with the appropriate Manager, Director or Senior Administrator as applicable. 2. Please see specific monitoring detailed in Tag A749. <p>Please note there is no A022 citation in this report as referenced in Finding #1. Nevertheless, the hospital took the following actions to assure appropriate handwashing facilities in the additional nurses station for PCU.</p> <p>Actions Taken</p> <ol style="list-style-type: none"> 1. The CNO directed that the use of Room #267 as a Nurses' Station be immediately discontinued. The two desks, computers and miscellaneous supplies were removed. The room was empty and available for patient use by 8:00pm on 03/05/09. The PCU nurses moved back to, and are currently using the 2W Nurses' Station (the approved nursing station for 2W) until the additional changes are made and approved. 2. The Plant Operations Manager (POM) met with the OSHPD Area Compliance Officer (ACO) and reviewed the OSHPD Plans to confirm that the plans were satisfactory. This additional nursing station is being added so that the PCU nurses can be closer to the PCU patients under their care, allowing for close observation and more rapid nursing response. The plans include connection to the nurse call system and installation of a sink with unrestricted access. The changes were deemed appropriate for temporary conversion of space. The Inspector of Record was notified and work began. 	<p>04/25/09</p> <p>03/05/09</p> <p>03/24/09</p>

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A 749	Continued From Page 6a	A 747	Continued From Page 6a	
A 749	<p>482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES</p> <p>The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.</p> <p>This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure the visitor of one patient in contact isolation (Patient 313) followed appropriate isolation precautions; 2. Ensure facility staff followed transmission-based precautions when caring for two patients in contact isolation (Patients 313 and 314); 3. Develop, implement, and maintain a process to ensure the adequate cleaning and use of re-useable headgear in the ORs and other restricted and semi-restricted areas; and, 4. Ensure facility staff followed manufacturer's recommendations for disinfectant use in one of two ORs and one of one newborn nurseries. <p>These failures resulted in the potential for the</p>	A 749	<p>3. The hospital submitted a written request for the temporary conversion of space to CaDPH. The request included a copy of the OSHPD approved plans.</p> <p>4. Room #267 will remain available for patient use until such time as CaDPH reviews and provides written approval for the space conversion, as requested by the hospital.</p> <p>5. Upon completion of the work identified in the plans, the room was inspected and verbally signed-off by local fire and OSHPD.</p> <p>6. On 04/21/09, the ADQO forwarded the OSHPD Certificate of Occupancy to the State and is currently awaiting written approval from CaDPH for the space conversion.</p> <p>Person Responsible: CNO Monitoring: The CNO ensures that Room #267 is not used as a nurses station until written approval from the State has been received.</p> <p>Please see responses in Tag A749 regarding the specific infection control findings.</p> <p>Infection Control Officer Responsibilities</p> <p>- Individual Employees Observed During Survey Actions Taken</p> <ol style="list-style-type: none"> 1. Managers followed-up with employees identified in the survey as not being compliant with hospital infection control procedures. Then the Manager worked with the HR Director to determine the appropriate corrective actions and/or discipline concerning each employee. 2. The CEO and ADQO disseminated information on the principals of infection prevention (hand hygiene, isolation precautions and surface cleaners) to all employees. This was done via open forum Town Hall meetings during all shifts on 03/24/06 and 03/26/09 and by attaching the information to all employee paychecks on 04/03/09. <p>Person Responsible The HR Director provided oversight to the employee performance management process. The IC Director in collaboration with Managers are responsible for assuring that healthcare workers comply with the policies related to infection prevention practices - isolation precautions and surface cleaners. Monitoring - See Leadership Rounding Section Below.</p>	<p>03/30/09</p> <p>03/30/09</p> <p>04/03/09</p> <p>04/21/09</p> <p>03/06/09 and ongoing</p> <p>03/20/09</p> <p>04/03/09</p>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 749 Continued From Page 7

source and spread of infections throughout both hospital campuses.

Findings:

1. During an observation at RSMC on March 5, 2009, at 10:30 a.m., accompanied by the IP, Patient 313 was in a room with a Contact Precautions isolation sign on the door. The sign indicated those entering the room were to wear gloves and a cover gown. Patient 313's wife was in the room and not wearing gloves or a cover gown. Patient 313's wife was observed touching the patient and surfaces in the environment, including the bedrails and bed clothing.

During a concurrent interview, Patient 313's wife stated she was told her husband was on antibiotics so she did not need to follow any precautions. The IP stated he had not been notified Patient 313's wife was non compliant with the isolation precautions. He stated there should be interventions and goals to get the wife to be compliant with the precautions.

The record for Patient 313 was reviewed on March 5, 2009. The record indicated Patient 313 had a diagnosis of pneumonia and MRSA of the sputum. The interdisciplinary care plan indicated the patient's wife was non-compliant with the isolation precautions. The care plan had no interventions or goals related to educating the patient's wife regarding contact precautions, or encouraging his wife to comply with the precautions.

The facility policy and procedure for contact precautions, dated August, 2008, was reviewed on March 5, 2009. The policy indicated family and visitors were to follow precautions.

A 749 Continued from Page 7

In addition to the action taken with individual employees, the Hospital took the additional actions for each type of finding as detailed below.

Isolation (Transmission-Based) Precautions Actions Taken

1. The IC Director reviewed the policy on Isolation Precautions to confirm the information was consistent with CDC Guidelines. 03/06/09

2. The IC Director convened a multidisciplinary meeting with clinical leadership to review, discuss and clarify IC practices. Recommendations for revisions were forwarded to the Medical Staff. 03/12/09

3. The Infection Control Committee Chair conducted the meeting of the Medical Staff Policy & Procedure Committee that reviewed and revised the Isolation Precautions policy to clarify the information available to the staff regarding:

a. Transmission-based precautions and required personal protective equipment.

b. Actions to take if a visitor does not comply with appropriate precautions.

4. The MEC approved the revised Isolation Precautions policy. 04/16/09

5. The IC Director revised the isolation precaution signs and educational material as necessary to be consistent with the updated policy. 04/25/09

6. The IC Director provided a FAQ handout to Managers and Directors as an employee reference related to infection control practices (Isolation basics, hand hygiene and surface cleaners). For those employees that provide direct patient care, the Managers completed staff education on isolation precautions. Managers are responsible for tracking which employees missed the education because of an infrequent work schedule or a leave of absence, and for being sure such an employee receives the education upon the employee's return to work. 04/25/09 and ongoing

7. Leadership members monitored the staff concerning compliance with transmission-based precautions done during the week of March 30, 2009. The results were as follows:

a. Use of proper attire - 97% compliance (108/111 observations)

b. Attire removed appropriately - 98% compliance (102/104 observations)

c. Visitor using appropriate precautions - 95% compliance (35/41 observations)

d. The monitors corrected any noncompliance that was observed and reeducated the staff person at the time of the observation.

03/30/09
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CA DEPT OF PUBLIC HEALTH
LICENSING & CERTIFICATION DIVISION

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A 749	Continued From Page 8 2a. During an observation at RSMC on March 5, 2009, at 10:30 a.m., accompanied by the IP, Patient 313 was in a room with a Contact Precautions isolation sign on the door. The sign indicated those entering the room were to wear gloves and a cover gown. The record for Patient 313 was reviewed on March 5, 2009. The record indicated Patient 313 had a diagnosis of pneumonia and MRSA of the sputum. The PT notes, dated March 4, 2009, indicated the PT ambulated Patient 313 in the hallway. During an interview with PT 1 on March 5, 2009, at 10:45 a.m., she stated when she ambulated the patient in the hallway, she wore a gown and gloves while assisting him. When asked if she had Patient 313 do anything special to prevent spreading microorganisms to staff and visitors in the hallway, she stated she did not have him wear anything special. She stated she did not know what the facility policy and procedure said about taking patients on isolation precautions into the hallway. During a concurrent interview with the IP, he stated the policy was for the patient to wear protective items, such as mask, gown and/or gloves, in order to protect staff and visitors. The facility policy and procedure for isolation precautions, dated August 2008, was reviewed on March 5, 2009. The policy indicated when patients were out of the room, staff was to take all necessary precautions to prevent infectious microorganisms from contaminating surfaces and others. b. During an observation at RSMC on March 5, 2009, at 10:50 a.m., Patient 314 was in a room with a sign on the door indicating Contact	A 749	Continued from Page 8 8. Responding to feedback from front-line care providers, the senior administrative team, including the IC Director and the Chief of Staff, further clarified the Isolation Precautions policy to require consistent use of the applicable personal protective equipment by all who enter an isolation room, specific to the category of precautions in effect. The CEO and the Chief of Staff approved the policy on 05/01/09, and the ADQO distributed the revised policy to clinical managers, who provided the updated information to direct care givers via a quick reference badge card. The IC Director revised and then distributed door signs regarding isolation precautions to all inpatient nursing units. Person Responsible The IC Director is responsible for reviewing compliance with the Isolation Precautions policy. The IC Director is supported by the Directors and Managers who are responsible for their employees' compliance with isolation and infection control practices. Monitoring: See Leadership Rounding below. - OR: Personal Head Coverings Actions Taken 1. When the surveyor identified a concern with the practice of wearing cloth head coverings, the practice was immediately discontinued. All members of the healthcare team are now required to wear disposable head coverings provided by the Hospital. 03/05/09 2. The requirement to wear hospital-provided disposable head coverings was approved at the Department of Surgery meeting. 03/05/09 3. The Perioperative Services Director reviewed the Surgical Attire policy and the current AORN Standards and revised the policy to include the current recommendations regarding surgical attire, including the requirement that only hospital-provided disposable head coverings are permitted. The revised policy was approved at the March Policy & Procedure meeting. 03/10/09 4. The Perioperative Director and Managers provided perioperative staff with education during morning Board Rounds regarding the requirement to wear hospital-provided disposable head coverings. They provided ongoing education during their rounding in the Perioperative area. 03/11/09 and ongoing	05/04/09	

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A 749	<p>Continued From Page 9</p> <p>Precautions were to be followed. The sign indicated gowns and gloves were to be worn for all interactions that could involve contact with the patient or the patient's environment. The sign also indicated hand hygiene was to be done prior to leaving the room.</p> <p>CNA 1 was observed inside the room, not wearing a gown or gloves. The CNA was touching the bedside table and removing something from the table. The CNA then walked out of the room without performing hand hygiene and went into a storage room where patient care supplies were kept. There was no sink or station in the storage room where the CNA could perform hand hygiene.</p> <p>During an interview with CNA 1 at 10:55 a.m., she stated she knew she was supposed to wear PPE when she went into room 314. She stated she went into the storage room to get something, but then noticed her pants were dirty because the cuffs of her pants were dragging on the floor, so she attempted to fold the cuffs up. The CNA's pant cuffs were covered with a large amount of gray fuzzy, dirty, and dusty appearing substance. The cuffs were dragging on the floor as CNA 1 walked around, including into and out of isolation precautions rooms. The CNA did not perform hand hygiene and did not follow transmission based precautions.</p> <p>3. During a tour of the OR at IVMC on March 2, 2009, the following was observed:</p> <p>a. at 11:10 a.m., RNFA 1 was in OR 4, where a surgical procedure was finishing. RNFA 1 was wearing a cloth hair cover. During an interview with RNFA 1 at 12:15 p.m., she stated she took the head gear home and washed it herself with her other laundry. She stated she did not know</p>	A 749	<p>Continued from Page 9</p> <p>5. The Women's Services Director and Managers provided Women's services staff with education during the Daily Lin-Up regarding the requirement to wear hospital-provided disposable head coverings. They provided ongoing education during their rounding in the Women's Services area.</p> <p>6. The revised/approved Surgical Attire policy was presented at the Department of Anesthesia meeting.</p> <p>7. Monitoring done by leadership team members during the week of March 30, 2009 demonstrated 100% compliance (50/50 observations) with the revised policy requiring that staff wear hospital provided, disposable head coverings in the OR and in other restricted, semi-restricted areas.</p> <p>Person Responsible: The Perioperative and Women's Services Directors are responsible for assuring compliance with the revised policy. Monitoring: See Leadership Rounding below.</p> <p>- Surface Cleaners Actions Taken</p> <p>1. During staff interviews, the EVS Manager determined that non-EVS employees sometimes asked to use the EVS cleaning supplies. This resulted in non-EVS staff members using a surface cleaner about which they had not been educated. Therefore, the Associate Administrator (AA) met with EVS Managers to discuss and review the use of surface cleaners. EVS Managers directed that EVS staff may not provide "their" cleaning supplies to non-EVS staff.</p> <p>2. Caviwipes are the standard hospitalwide surface cleaner. When Caviwipes are not appropriate for use on a particular type of equipment, the IC Director must be consulted to identify an approved alternative product. The department manager may then order the approved product for his/her unit and assure that staff members receive information regarding the appropriate use of the surface cleaner before the surface cleaner is first used.</p> <p>3. Each Manager/Director reviewed the surface cleaners used in their areas to confirm that the appropriate cleaning agents were readily available and remain on surface for the correct length of time.</p> <p>4. Monitoring done by leadership team members during the week of March 30, 2009 demonstrated 100% compliance (131/131 observations) with the use of the appropriate type of surface disinfectant and</p>	<p>03/11/09 and ongoing</p> <p>03/12/09</p> <p>03/30/09 and ongoing</p> <p>03/10/09</p> <p>03/10/09 and ongoing</p> <p>03/13/09</p> <p>03/30/09</p>

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A 749	<p>Continued From Page 10</p> <p>what the temperature of her water was at home. She stated she used regular detergent when washing the head gear. She stated she carried the headgear into work in a bag that contained other items; and,</p> <p>b. at 12:20 p.m., Surg Tech 1 was observed in OR 1 assisting with a surgical procedure, wearing a cloth hair cover. During an interview at 12:25 p.m., Surg Tech 1 stated she washed the cloth head gear at home with regular detergent and hot water with her other laundry. She stated she did not know what the temperature of her water was at home. She stated she brought the head gear to work in a bag that contained other items.</p> <p>During an interview with the Director of Surgical Services on March 2, 2009, at 12:35 p.m., she stated the facility policy allowed staff to take the reusable cloth head gear home to launder. She stated the staff carried the head gear back and forth from home and work in purses or other types of bags, usually with other items.</p> <p>During an interview with the Director of Surgical Services at RSMC on March 5, 2009, at 9:30 a.m., she stated the staff carried their reusable cloth headgear from home to work in bookbags and other personal bags. She stated there was no process in place to ensure cloth caps were cleaned appropriately at home by the employees. She stated they trusted the employees to clean them.</p> <p>The policy for both IVMC and RSMC titled, "Surgical Attire," dated March 2006, was reviewed on March 5, 2009. The policy indicated surgical attire included scrub clothes and hair coverings. The second page of the policy indicated personalized, individual caps may be</p>	A 749	<p>Continued from Page 10</p> <p>99% compliance (130/131 observations) with complying with the manufacturer's guidelines for surface contact time.</p> <p>5. The IC Director developed a quick reference badge card on the types of surface cleaners approved for use in the Hospital; the card was distributed to all employees on 05/04/09. Person Responsible: IC Director, Associate Administrator Monitoring: See Leadership Rounding below.</p> <p>Monitoring - Leadership Rounding</p> <p>1. Rounding by the Infection Control staff continues with direct feedback provided to any noncompliant employee at the time. The IC staff provides written findings to the unit Manager and to the Senior Team member.</p> <p>2. The BEST Council's rounding teams perform weekly rounds on the nursing units, according to the schedule and provide the unit manager with a copy of their observations so the manager understands what is working well and what actions need to be taken to correct noncompliance or improve practices.</p> <p>3. The rounding teams are responsible for observing compliance with isolation precautions, personal head coverings, and the appropriate use of surface cleaners. This data is sent to the ADQO for reporting purposes. Reports are discussed at the Operational PI Committee, the PIRM Committee, the MEC and the Board, with action planning as appropriate.</p>	<p>05/04/09</p> <p>03/06/09 and ongoing</p> <p>03/30/09 and ongoing</p> <p>03/30/09 and ongoing</p>

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A 749 Continued From Page 11

A 749 Continued From Page 11

worn in surgery, and reusable headgear must be laundered when soiled and after each use. The policy did not include information regarding how the items were to be laundered or carried into the facility. There was no information regarding how the facility would ensure the items were appropriately cleaned and transported to minimize the transmission of microorganisms to and from the facility.

According to the AORN 2008 perioperative standards and recommended practices related to the laundering of scrubs and headgear:

1. home laundering of surgical attire is not recommended;
2. reusable surgical attire, including cloth hats, should be laundered by a designated, facility approved and monitored, commercial laundry; and,
3. if home laundering is permitted by facility policy, the following criteria should be met:
 - a. use an automatic washer and hot air dryer;
 - b. use water temperature of 110° F to 125° F to facilitate microbial kill;
 - c. use chlorine bleach;
 - d. use detergent according to manufacturer's recommendations;
 - e. launder surgical attire in a separate load with no other items;
 - f. launder surgical attire as the last load after all other items have been laundered;

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A 749	<p>Continued From Page 12</p> <p>g. wash hands immediately after placing laundry in the washing machine;</p> <p>h. keep laundry items completely submerged during the entire wash cycle to facilitate removal of soil and microorganisms;</p> <p>i. avoid placing hands or arms in the laundry or rinse water to keep items submerged;</p> <p>j. thoroughly clean the door and lid of the washing machine before removing the laundered attire to prevent reintroduction of contaminants on clean attire when removing it from the washing machine and before placing it in the dryer;</p> <p>k. use the highest drying setting possible that is safe for the material of attire construction;</p> <p>l. promptly remove attire when dry to avoid desiccation (dehydration) of materials; and,</p> <p>m. protect the attire from contamination during transfer, storage, and transport to the practice setting.</p> <p>The facility had not developed, implemented, or maintained a process to ensure staff was following the AORN recommendations when laundering their surgical attire at home.</p> <p>4a. During a tour of the RSMC OR on March 5, 2009, at 9:24 a.m., RT 1 was assisting with cleaning OR 1 following a surgical procedure. During a concurrent interview, the RT stated the cloth he was using was wet with solution from a bottle on the shelf. He stated the solution was 10% bleach that was pre-mixed. When asked how he knew what was in the bottle, he stated a nurse told him.</p>	A 749	Continued From Page 12	

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The surfaces that were being cleaned were dry within two to three minutes of becoming wet with the cleaning solution.

The label of the bottle stated the solution was Virex TB with a disinfection contact time of 10 minutes.

During an additional interview with RT 1 at 9:38 a.m., he again stated he was using the solution in the bottle and the solution was bleach. The RT stated he did not read what was on the label, but just went by what he was told by someone else. He did not know what solution he was using to clean with or how to use the solution.

b. During a tour of the newborn nursery at RSMC on March 5, 2009, at 9:55 a.m., RN 8 was observed cleaning an infant isolette. The RN wiped a wet cloth over the mattress and plastic sides of an isolette, then immediately dried them off. During a concurrent interview, RN 8 stated she was using Virex 256 and she usually dried the items off immediately. She stated the main disinfecting chemical used was the Virex 256.

The manufacturer label of the Virex 256 was reviewed on March 5, 2009. The label indicated the solution was to remain wet on the surface for 10 minutes in order to be effective as a disinfectant.

A 749 Continued From Page 13

A 951 482.51(b) OPERATING ROOM POLICIES

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.

A 951 Operating Room Policies

- OR: Personal Head Coverings Actions Taken

1. When the surveyor identified a concern with the practice of wearing cloth head coverings, the practice was immediately discontinued. All members of the healthcare team are now required to wear disposable head coverings provided by the Hospital.

03/05/09

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A 951	Continued From Page 14	A 951	Continued From Page 14	
	<p>This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to:</p> <ol style="list-style-type: none"> Develop, implement, and maintain a process to ensure the adequate cleaning and use of re-useable headgear in the ORs and other restricted and semi-restricted areas; and, Ensure facility staff followed manufacturer's recommendations for disinfectant use in one of two ORs. <p>These failures resulted in the potential for the source of infections in surgical patients and the spread of infections throughout both hospital campuses.</p> <p>Findings:</p> <ol style="list-style-type: none"> During a tour of the OR at IVMC on March 2, 2009, the following was observed: <ol style="list-style-type: none"> at 11:10 a.m., RNFA 1 was in OR 4, where a surgical procedure was finishing. RNFA 1 was wearing a cloth hair cover. During an interview with RNFA 1 at 12:15 p.m., she stated she took the head gear home and washed it herself with her other laundry. She stated she did not know what the temperature of her water was at home. She stated she used regular detergent when washing the head gear. She stated she carried the headgear into work in a bag that contained other items; and, at 12:20 p.m., Surg Tech 1 was in OR 1 		<ol style="list-style-type: none"> The requirement to wear hospital-provided disposable head coverings was approved at the Department of Surgery meeting. The Perioperative Services Director reviewed the Surgical Attire policy and the current AORN Standards and revised the policy to include the current recommendations regarding surgical attire, including the requirement that only hospital-provided disposable head coverings are permitted. The revised policy was approved at the March Policy & Procedure meeting. The Perioperative Director and Managers provided perioperative staff with education during morning Board Rounds regarding the requirement to wear hospital-provided disposable head coverings. They provided ongoing education during their rounding in the Perioperative area. The Women's Services Director and Managers provided Women's services staff with education during the Daily Line-Up regarding the requirement to wear hospital-provided disposable head coverings. They provided ongoing education during their rounding in the Women's Services area. The revised/approved Surgical Attire policy was presented at the Department of Anesthesia meeting. Monitoring done by leadership team members during the week of March 30, 2009 demonstrated 100% compliance (50/50 observations) with the revised policy requiring that staff wear hospital provided, disposable head coverings in the OR and in other restricted, semi-restricted areas. Person Responsible: The Perioperative and Women's Services Directors are responsible for assuring compliance with the revised policy. Monitoring: See Leadership Rounding below <p>- Individual Employees Observed During Survey Actions Taken</p> <ol style="list-style-type: none"> Managers followed-up with employees identified in the survey as not being compliant with hospital infection control procedures. Then the Manager worked with the HR Director to determine the appropriate corrective actions and/or discipline concerning each employee. 	<p>03/05/09</p> <p>03/10/09</p> <p>03/11/09 and ongoing</p> <p>03/11/09 and ongoing</p> <p>03/12/09</p> <p>03/30/09</p> <p>03/20/09</p>

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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 03/05/2009
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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 951	<p>Continued From Page 15</p> <p>assisting with a surgical procedure, wearing a cloth hair cover. During an interview at 12:25 p.m., Surg Tech 1 stated she washed the cloth head gear at home with regular detergent and hot water with her other laundry. She stated she did not know what the temperature of her water was at home. She stated she brought the head gear to work in a bag that contained other items.</p> <p>During an interview with the Director of Surgical Services at IVMC, on March 2, 2009, at 12:35 p.m., she stated the facility policy allowed staff to take the reusable cloth head gear home to launder. She stated the staff carried the head gear back and forth from home and work in purses or other types of bags, usually with other items.</p> <p>During an interview with the Director of Surgical Services at RSMC on March 5, 2009, at 9:30 a.m., she stated the staff carried their reusable cloth headgear from home to work in bookbags and other personal bags. She stated there was no process in place to ensure cloth caps were cleaned appropriately at home by the employees. She stated they trusted the employees to clean them.</p> <p>The policy for both IVMC and RSMC titled, "Surgical Attire," dated March 2006, was reviewed on March 5, 2009. The policy indicated surgical attire included scrub clothes and hair coverings. The second page of the policy indicated personalized, individual caps may be worn in surgery, and reusable headgear must be laundered when soiled and after each use. The policy did not include information regarding how the items were to be laundered or carried into the facility. There was no information regarding how the facility would ensure the items were appropriately cleaned and transported to</p>	A 951	<p>Continued From Page 15</p> <p>2. The CEO and ADQO conducted Town Hall meetings for the staff reaching all shifts. They reviewed and discussed principles of infection prevention (hand hygiene, isolation precautions, and surface cleaners), and answered questions. Staff were reminded to use the appropriate practices with every patient, every time.</p> <p>3. CEO sent a memorandum to all employees stressing the importance of infection prevention practices. The memorandum was distributed through the Joint Leadership team, by email to "All Groups" and in writing included with payroll checks.</p> <p>Person Responsible The HR Director provided oversight to the employee performance management process. The IC Director in collaboration with Managers are responsible for assuring that healthcare workers comply with the policies related to infection prevention practices – isolation precautions and surface cleaners. Monitoring – See Leadership Rounding Section Below.</p> <p>– Surface Cleaners Actions Taken 1. During staff interviews, the EVS Manager determined that non-EVS employees sometimes asked to use the EVS cleaning supplies. This resulted in non-EVS staff members using a surface cleaner about which they had not been educated. Therefore, the Associate Administrator (AA) met with EVS Managers to discuss and review the use of surface cleaners. EVS Managers directed that EVS staff may not provide "their" cleaning supplies to non-EVS staff.</p> <p>2. Caviwipes are the standard hospitalwide surface cleaner. When Caviwipes are not appropriate for use on a particular type of equipment, the IC Director must be consulted to identify an approved alternative product. The department manager may then order the approved product for his/her unit and assure that staff members receive information regarding the appropriate use of the surface cleaner before the surface cleaner is first used.</p> <p>3. Each Manager/Director reviewed the surface cleaners used in their areas to confirm that the appropriate cleaning agents were readily available and remain on surface for the correct length of time.</p>	<p>03/26/09</p> <p>04/03/09</p> <p>03/10/09</p> <p>03/10/09 and ongoing</p> <p>03/13/09</p>

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A 951	<p>Continued From Page 16</p> <p>minimize the transmission of microorganisms to and from the facility.</p> <p>According to the AORN 2008 perioperative standards and recommended practices related to the laundering of scrubs and headgear:</p> <ol style="list-style-type: none"> 1. home laundering of surgical attire is not recommended; 2. reusable surgical attire, including cloth hats, should be laundered by a designated, facility approved and monitored, commercial laundry; and, 3. if home laundering is permitted by facility policy, the following criteria should be met: <ol style="list-style-type: none"> a. use an automatic washer and hot air dryer; b. use water temperature of 110° F to 125° F to facilitate microbial kill; c. use chlorine bleach; d. Use detergent according to manufacturer's recommendations; e. launder surgical attire in a separate load with no other items; f. launder surgical attire as the last load after all other items have been laundered; g. wash hands immediately after placing laundry in the washing machine; h. keep laundry items completely submerged during the entire wash cycle to facilitate removal of soil and microorganisms; 	A 951	<p>Continued From Page 16</p> <ol style="list-style-type: none"> 4. Monitoring done by leadership team members during the week of March 30, 2009 demonstrated 100% compliance (131/131 observations) with the use of the appropriate type of surface disinfectant and 99% compliance (130/131 observations) with complying with the manufacturer's guidelines for surface contact time. 5. The IC Director developed a quick reference badge card on the types of surface cleaners approved for use in the Hospital; the card was distributed to all employees on 05/04/09. Person Responsible: IC Director, Associate Administrator Monitoring: See Leadership Rounding below. <p>Monitoring – Leadership Rounding</p> <ol style="list-style-type: none"> 1. Rounding by the Infection Control staff continues with direct feedback provided to any noncompliant employee at the time. The IC staff provides written findings to the unit Manager and to the Senior Team member. 2. The BEST Council's rounding teams perform weekly rounds on the nursing units according to the schedule and provide the unit manager with a copy of their observations so the manager understands what is working well and what actions need to be taken to correct noncompliance or improve practices. 3. The rounding teams are responsible for observing compliance with isolation precautions, personal head coverings, and the appropriate use of surface cleaners. This data is sent to the ADQO for reporting purposes. Reports are discussed at the Operational PI Committee, the PIRM Committee, the MEC and the Board, with action planning as appropriate. 	<p>03/30/09</p> <p>05/04/09</p> <p>03/06/09 and ongoing</p> <p>03/30/09 and ongoing</p> <p>03/30/09 and ongoing</p>

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A 951	Continued From Page 17	A 951	Continued From Page 17	
	<p>i. avoid placing hands or arms in the laundry or rinse water to keep items submerged;</p> <p>j. thoroughly clean the door and lid of the washing machine before removing the laundered attire to prevent reintroduction of contaminants on clean attire when removing it from the washing machine and before placing it in the dryer;</p> <p>k. use the highest drying setting possible that is safe for the material of attire construction;</p> <p>l. promptly remove attire when dry to avoid desiccation (dehydration) of materials; and,</p> <p>m. protect the attire from contamination during transfer, storage, and transport to the practice setting.</p> <p>The facility had not developed, implemented, or maintained a process to ensure staff was following the AORN recommendations when laundering their surgical attire at home.</p> <p>2. During a tour of the RSMC OR on March 5, 2009, at 9:24 a.m., RT 1 was assisting with cleaning OR 1 following a surgical procedure. During a concurrent interview, the RT stated the cloth he was using was wet with solution from a bottle on the shelf. He stated the solution was 10% bleach that was pre-mixed. When asked how he knew what was in the bottle, he stated a nurse told him.</p> <p>The surfaces that were being cleaned were dry within two to three minutes of becoming wet with the cleaning solution.</p> <p>The label of the bottle stated the solution was Virex TB with a disinfection contact time of 10</p>			

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A 951	Continued From Page 18 minutes. During an additional interview with RT 1 at 9:38 a.m., he again stated he was using the solution in the bottle and the solution was bleach. The RT stated he did not read what was on the label, but just went by what he was told by someone else. He was not aware of what solution he was using for cleaning or how to use it.	A 951	Continued From Page 18	

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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 second revisit following a Full Certification Survey authorized by the Centers for Medicare and Medicaid Services, Region IX, conducted March 2 through March 5, 2009.</p> <p>Representing the Department of Public Health: Tina Buchanan, HFEN Omar Fausto, HFEN Jennifer Hoke, RN, IC Consultant</p> <p>Abbreviations used in this document:</p> <p>ACO - Area Compliance Officer AORN - Association of Operating Room Nurses arc - intensely hot discharge of electricity CBC - California Building Code CCR - California Code of Regulations CDPH - California Department of Public Health CEC - California Electrical Code CNA - Certified Nursing Assistant COO - Chief Operating Officer C-section - Cesarean Section IC - Infection Control IOR - Inspector of Record IP - Infection Preventionist IVMC - Inland Valley Medical Center MRSA - Methicillin Resistant Staphylococcus Aureus NS - Nurses' Station OR - Operating Room OSHPD - Office of Statewide Healthcare Planning and Development PCU - Progressive Care Unit</p>	{A 000}		

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

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{A 000}	Continued From page 1 PPE - Personal Protective Equipment PT - Physical Therapist RN - Registered Nurse RNFA - Registered Nurse First Assist RSMC - Rancho Springs Medical Center RT - Radiology Technologist Surg - Surgical Tech - Technician Tele - Telemetry w/o - Without	{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 facility failed to ensure one patient room (Room 267) was not used as a nurses' station until modifications required by CDPH and OSHPD were completed, resulting in the potential for: a. delay in care due to no patient/nurse call system; b. spread of infection due to no handwashing sink or hand hygiene area; and, c. spread of fire due to no magnetic hold open device or self closing, positive latching device on the door (A022). This failure continued for a period of four and one half months after the facility was notified by OSHPD the room being used as a PCU nurse's station did not include the features required by the State of California.	{A 020}			

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{A 020}	Continued From page 2 The facility also failed to report an arc from a bovie in the RSMC OR that caused a burn to one surgical patient's skin (Patient 101), resulting in the potential for unsafe practices to go unrecognized due to no investigation of the incident (A022). The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the provision of quality healthcare in a safe and effective manner.	{A 020}		
{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. This Standard is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one patient room (Room 267) was not used as a nurses' station until modifications required by CDPH and OSHPD were completed, resulting in the potential for: a. delay in care due to no patient/nurse call system; b. spread of infection due to no handwashing sink or hand hygiene area; and c. spread of fire due to no magnetic hold open device or self closing, positive latching device on the door.	{A 022}		

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{A 022}	<p>Continued From page 3</p> <p>The facility also failed to report an arc from a bovie in the RSMC OR that caused a burn to one surgical patient's skin (Patient 101), resulting in the potential for unsafe practices to go unrecognized due to no investigation of the incident.</p> <p>Findings:</p> <p>1. During a tour of the PCU at IVMC on March 2, 2009, at 9:35 a.m., patient room 267 was observed being used as a nurses' station. The room contained two desks with computers, a chart rack with PCU patient charts, papers used for charting, telephones, and office supplies. The room did not have a sink, a self closing door with a magnetic hold open device, or a nurse call system:</p> <p>a. as the room was a patient room, there was a bathroom with a sink. Having the only accessible sink in the bathroom meant the staff had to open the bathroom door with soiled hands to get to the sink. If somebody was using the bathroom, the staff did not have access to a sink for handwashing;</p> <p>b. patient rooms do not have a magnetic hold open and self closing device on them. When a fire alarm is sounded, patient room doors are closed manually by the nursing staff so the nurses can check on the safety of their patients. Other doors that are left open on the unit require a magnetic device to hold them open that releases and self closes in the event of a fire alarm. This closure of the doors helps to contain the fire. Not having the device on the nurse's station door meant if a fire started in the station (with paper and charts to fuel the fire) the fire would not be contained and could spread to other</p>	{A 022}		