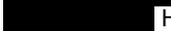
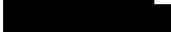
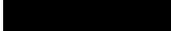
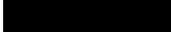
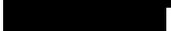
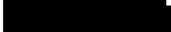
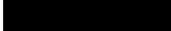


CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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 10/05/2007
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE, MURRIETA, CA 92562 RIVERSIDE COUNTY
--	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p>E 000 Initial Comments</p> <p>The following reflects the findings of the California Department of Public Health during a Full Medicare survey.</p> <p>On October 2, 2007, at 6:05 p.m., Immediate Jeopardy (IJ) was identified regarding the temperature controls in two of two food storage freezers. The IJ was abated on October 3, 2007, at 8 a.m.</p> <p>Representing the Department:</p> <p>  HFEN;  HFEN;  HFEN;  HFEN;  MD;  Nutrition Consultant;  Pharmacy Consultant;  Pharmacy Consultant; and  Occupational Therapy Consultant. </p> <p>The IJ resulted in the potential for growth of microorganisms and food borne illness in patients and visitors.</p> <p>A 012 1280.1 (a) HSC Section 1280</p> <p>If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an</p>			
--	---	--	--	--

Event ID:8QOU11

3/18/2008

12:41:39PM

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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 10/05/2007
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE, MURRIETA, CA 92562 RIVERSIDE COUNTY
--	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p>Continued From page 1</p> <p>administrative penalty in an amount not to exceed twenty-five thousand dollars (\$25,000) per violation.</p> <p>A 014 1280.1 (c) HSC Section 1280</p> <p>For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.</p> <p>T22 DIV5 CH1 ART3-70273 (k) (3). Dietetic Service General Requirements</p> <p>(k) Food Storage.</p> <p>(3) All readily perishable foods or beverages capable of supporting rapid and progressive growth of microorganisms which can cause food infections or food intoxication shall be maintained at temperatures of 7 degrees Celsius (45 degrees Fahrenheit) or below, or at 60 degrees Celsius (140 degrees Fahrenheit) or above, at all times, except during necessary periods of preparation and service. Frozen food shall be stored at -18 degrees Celsius (0 degrees Fahrenheit) or below.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper temperature controls in two of two food storage freezers, resulting in the potential for growth of microorganisms and food borne illness in patients and visitors. The facility also failed to ensure the</p>			
--	---	--	--	--

Event ID:8QOU11

3/18/2008

12:41:39PM

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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 10/05/2007
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE, MURRIETA, CA 92562 RIVERSIDE COUNTY
--	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p>Continued From page 2</p> <p>proper storage of ready to eat food items, resulting in the potential for juices from raw fish and sausage dripping on the ready to eat food items, cross contamination, and food borne illness in patients and visitors.</p> <p>Findings:</p> <p>During the initial tour of the kitchen at the Rancho Springs Medical Center Campus on October 2, 2007, at 10:20 a.m., a build-up of ice on the freezer floor, measuring approximately 12 inches by 8 inches, on the northeast corner was observed. Other areas of the floor had solidified chunks of ice. Ice was also observed on the tops of food, and on the boxes stored on the shelves closest to the ceiling.</p> <p>The following frozen items, stored in the freezer, were observed to have layers of ice crystals on the surface (a common sign of thawing and refreezing);</p> <ul style="list-style-type: none"> a. Pans of cooked beef casserole and vegetable lasagna had layers of ice on the top; b. A pan containing tilapia had similar ice crystals in the corners, and dried out, freezer burned edges on some of the raw fish pieces; c. A box containing chorizo sausage had ice crystals and chunks of ice inside. The chorizo was frozen as a solid block, not in individual pieces; d. A box of precooked chicken fillets had ice crystals inside the box. <p>The Director of Nutrition and Food Service (DNFS) stated that she did not know what the signs of thawing and refreezing were. She stated that she</p>			
--	--	--	--	--

Event ID:8QOU11

3/18/2008

12:41:39PM

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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 10/05/2007
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE, MURRIETA, CA 92562 RIVERSIDE COUNTY
--	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p>Continued From page 3</p> <p>did not know if the ice crystals found on the food in the freezer were a result of food thawing and refreezing, or if it was from the food being placed directly in the freezer after cooking. The DNFS stated that if the food was placed directly in the freezer after cooking, the staff did not go through the proper cooling procedures before storing food in the freezer.</p> <p>During an interview with the DNFS and the Director of Plant Operations (DPO) on October 2, 2007, at 4:45 p.m., the DPO stated that the hospital suffered several power outages this summer and, on one occasion, up to seven power interruptions in one day. He stated that dietary staff called to inform his department each time there was an outage.</p> <p>Inside the freezer, cooked and ready to eat food items (ice, french toast, and pizza crust) were stored on shelves directly under raw fish and sausage. The Food Services Manager (FSM) stated that he was aware of the proper order of storage to prevent cross-contamination in the refrigerator, but that the facility had not utilized that same principle in the freezers.</p> <p>The lead dietary staff present during the tour stated that the freezer had condensation problems, and that it had been reported to their plant operations staff several times. Another employee indicated that, "a while back," there was a power outage in the facility, and that every time there was a power outage, the freezer took about one hour to "kick in" after the power was restored. The employee stated</p>			
--	--	--	--	--

Event ID:8QOU11

3/18/2008

12:41:39PM

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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 10/05/2007
NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE, MURRIETA, CA 92562 RIVERSIDE COUNTY		
(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) COMPLETE DATE
	<p>Continued From page 4</p> <p>that there was a power outage sometime in September, in which the freezer was out for an extended period of time, "about" 4 hours. A review of the cafeteria register showed that calls were made to Plant Operations to report power outages in the month of September 2007. The DNFS stated that she did not know how many hours the freezer was non operational due to the power outages, or if the temperatures in the freezers fluctuated during the power outages.</p> <p>During an inspection of the outside freezer on October 2, 2007, at 11 a.m., a large mass of ice was observed, measuring approximately 40 inches long and 10 inches thick, on the east side of the wall of the freezer. There were icicles on the shelves all around the freezer, formed as a result of dripping water.</p> <p>The DNFS and FSM were present during the observation. Both stated that this outside freezer worked well, but that they had problems with ice build up, which had been reported to plant operations on several occasions. The FSM stated that every time the power went out and the freezer inside went off, the staff would move some of the frozen foods to the outside freezer, and the frequent opening and closing of the doors may have resulted in fluctuations in the outside freezer temperature. The FSM stated that it was his responsibility to clean the excess ice formed in the freezer. The FSM stated that he did not know how long ago the task had been completed.</p> <p>The refrigerator and freezer temperature logs for the</p>			

Event ID:8QOU11

3/18/2008

12:41:39PM

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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 10/05/2007
NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE, MURRIETA, CA 92562 RIVERSIDE COUNTY		
(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) COMPLETE DATE
	<p>Continued From page 5</p> <p>month of September 2007 were reviewed on October 2, 2007. The temperatures were checked every 12 hours, and the log showed no temperatures out of range. The DNFS agreed that this meant that the temperatures were in range at the times they were checked, but it did not represent any fluctuations in temperatures that may have occurred during the power outages when the inside freezer was off, and the outside freezer was being opened and closed frequently. There was no documentation of the power outages on the log, and no evidence that the freezer temperatures were monitored during the power outages.</p> <p>The failure of the hospital to monitor and maintain the proper refrigerator and freezer temperatures for an undetermined length of time highly resulted in the increased possibility of the growth of microorganisms in the food stored in the refrigerator and freezers. Some food-borne microorganisms produce toxins, which are not destroyed by heat. These toxins do not result in a change in smell or appearance of food. The presence of such a toxin in food served to any group of people would result in a food-borne illness. Hospital patients are a highly susceptible population with already immune compromised systems. This kind of food - borne illness could be devastating to them due to their immune-compromised state because they may have difficulty in fighting the infection that, otherwise, may cause a mild illness in a healthy population.</p> <p>During the team meeting on October 2, 2007, at 4:15 p.m., the team reviewed the above findings,</p>			

Event ID:8QOU11

3/18/2008

12:41:39PM

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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 10/05/2007
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE, MURRIETA, CA 92562 RIVERSIDE COUNTY
--	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p>Continued From page 6</p> <p>and determined that the deficient practice met the criteria for Immediate Jeopardy. The Chief Financial Officer (CFO) was notified of the Immediate Jeopardy on October 2, 2007, at 6:05 p.m.</p> <p>On October 3, 2007, at 8 a.m., an acceptable plan of correction was received from the facility, which consisted of;</p> <p>a. Locking the inside and outside freezers to prevent inadvertent access;</p> <p>b. Discarding all foods that were stored in the inside and outside freezers;</p> <p>c. Holding storage of food in the inside and outside freezers until they could be assured that both freezers were operating properly;</p> <p>d. Preparing meals with fresh, non frozen foods;</p> <p>e. Arranging for frozen foods to be brought from the Inland Valley Medical Center campus or purchased for same delivery, in the event the use of frozen foods became necessary; and,</p> <p>f. Packaging and refrigerating unused foods until the freezers were operating properly.</p> <p>The CFO and (Chief Nursing Officer) CNO were notified that the Immediate Jeopardy was abated on October 3, 2007, at 8 a.m.</p> <p>The Plant Operations work order summary for the Dietary department was reviewed with the DPO on</p>			
--	---	--	--	--

Event ID:8QOU11

3/18/2008

12:41:39PM

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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 10/05/2007
NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM			STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE, MURRIETA, CA 92562 RIVERSIDE COUNTY		
(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) COMPLETE DATE	
	<p>Continued From page 7</p> <p>October 5, 2007. The summary did not show any calls from the Dietary department regarding the problems with the freezer for the month of September 2007. The DPO was unable to provide a log of calls made by the Dietary department regarding power outages in the month of September 2007.</p> <p>The failure of the facility to ensure proper food temperature controls placed patients and visitors at risk for serious harm due to the potential for growth of microorganisms and food borne illness.</p>				

Event ID:8QOU11

3/18/2008

12:41:39PM

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.