

COPY



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FORM APPROVED

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 250000507	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/06/2008
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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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(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
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E 000 Initial Comments

E 000

The following reflects the findings of the California Department of Public Health during a complaint investigation. An unannounced visit was conducted on April 16, 2008, and a subsequent unannounced visit was conducted on June 6, 2008.

Complaint # CA00146788

Representing the Department of Public Health:

██████████ HFEN
██████████ HFEN
██████████ HFES

The Department was able to substantiate a violation of the regulations.

The COO, Assistant CNO, and Director of PI were notified Immediate Jeopardy was identified on June 6, 2008, at 9:05 a.m. The Immediate Jeopardy was identified due to the facility's failure to ensure staffing for ICU patients in accordance with minimum staffing requirements, by failing to ensure the physical presence of two ICU trained and experienced nurses on the MST floor when there was an ICU patient present.

After implementation of an acceptable plan of correction, the Director of PI and the COO were notified the Immediate Jeopardy was abated on June 6, 2008, at 11:15 a.m.

A written cease and desist 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 MST beds to ICU beds.

An acceptable plan of correction was received on June 6, 2008, at 2:55 p.m.

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

Catherine Wamey

TITLE

CNO

(X6) DATE

12/31/08

STATE FORM

021199

WJMG11

If continuation sheet 1 of 13

OK (TW)

received
JAN 05 2009

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E 000 Continued From Page 1

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Abbreviations used in this document:

- AMI - Acute Myocardial Infarction
- CCR - California Code of Regulations
- CN - Charge Nurse
- CNO - Chief Nursing Officer
- CO2 - Carbon Dioxide
- COO - Chief Operating Officer
- DKA - Diabetic Ketoacidosis
- ED - Emergency Department
- GI - Gastrointestinal
- HS - House Supervisor
- ICU - Intensive Care Unit
- MST - Medical Surgical/Telemetry
- PACU - Post Anesthesia Recovery Unit
- PI - Performance Improvement
- RN - Registered Nurse

Response to complaint #CA00146788

E1157 T22 DIV5 CH1 ART6-70493(a)(1) Intensive Care Service General Requirements

E1157 T22 DIV5 CH1 ART6-70493(a)(1) Intensive Care Service General Requirements

(1) Admission, discharge and transfer policies.

This RULE: is not met as evidenced by:

Based on observation, interview, and record review, the facility failed, for one of two patients whose conditions deteriorated while on the MST floor (Patient 5), to comply with their written criteria for admission to ICU, resulting in Patient 5 receiving a lower intensity of care than required, and the potential for further deterioration in her condition.

Findings:

During an interview with the ICU CN on June 6, 2008, at 7:20 a.m., the CN stated there was currently an ICU patient on the MST floor (as of 7

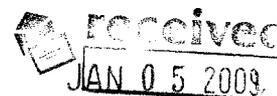
A. What corrective action for patients identified to have been affected by deficient practice?

- On the day of admission and prior to the survey team's finding, the RN caring for patient #5 identified a concern regarding the patient's admission status and had already contacted the physician and obtained an order for ICU level of care. No additional intervention was required to address this finding as it relates to this specific patient.

1. In agreement with on site surveyors from CA DPH the following actions were immediately put into place on 6/6/08 to address any potential patients that could be affected by the same deficient practice:

06/06/08

- a. Patients requiring ICU level of care will be admitted to a licensed ICU bed.
- b. When there is no bed available in the ICU, the following actions will be taken:



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E1157	<p>Continued From Page 2</p> <p>a.m.) because the patient, "went bad," on the floor and all of the ICU beds were full. The CN stated she sent one ICU nurse up to the floor to care for the ICU patient.</p> <p>During a tour of the MST floor on June 6, 2008, at 7:55 a.m., Patient 5 was observed in a MST bed with one nurse (RN 1) assigned to care for her. The patient was pale in color with rapid, labored respirations in a Kussmaul pattern (very deep and labored breathing found among people with severe acidosis), and facial grimacing.</p> <p>A review of the record indicated Patient 5, a 36 year old female, presented to the ED on June 5, 2008, at 11:15 p.m., with a complaint of diabetes with a high blood sugar and vomiting.</p> <p>According to the ED record, labs done at 12:05 a.m. showed a CO2 of 7 (normal 22-26), and an initial blood sugar of 376 (the facility normal range was 70-105). The patient's blood sugar at 3:50 a.m. had increased to 504. Patient 5 was admitted to the MST floor at 4:30 a.m. There was no indication in the ED record the patient was considered a candidate for admission to ICU.</p> <p>The record indicated on arrival to the MST floor, Patient 5 had labored respirations at a rate of 32/minute. At 6:40 a.m., lab results indicating DKA (a metabolic disorder characterized by high blood sugar, high respiratory rate, low carbon dioxide, and low blood pH) were called to the physician, and an insulin drip (continuous infusion of a medication to lower the blood sugar) was ordered (requiring ICU care).</p> <p>The facility ICU policy titled, "Admission Criteria," was reviewed on June 6, 2008. The policy indicated the following patients would be</p>	E1157	<p>Continued from Page 2</p> <ul style="list-style-type: none"> - A patient who presents to the Emergency Department and requires ICU level of care will be held in the Emergency Department until an ICU bed is available. - A postoperative patient requiring ICU level of care will remain in the Post Anesthesia Care Unit (PACU) until an ICU bed becomes available. - A patient on the Medical-Surgical Units whose clinical condition changes and requires ICU level of care will be held on the Medical-Surgical Unit until an ICU bed becomes available. <p>c. Staffing plan for patients requiring ICU level who are not physically located in the ICU is as follows:</p> <ul style="list-style-type: none"> - 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. - When a Medical-Surgical patient's condition changes and requires an ICU level of care, two ICU nurses will be physically present on the unit. The appropriate nurse to patient ratio related to the ICU level of care is maintained. d. The House Supervisor (HS), an experienced registered nurse, reviews all patients for appropriate level of care placement. For a request for bed placement that is not consistent with the designated unit's admission criteria, the HS will clarify the patient's status with admitting physician or, if needed, through implementation of Chain of Command policy. <p>B. How other patients having the potential to be affected by the same deficient practice will be identified, and what corrective actions will be taken.</p> <p>All patients requiring admission to the hospitals are reviewed for appropriate level of services by the House Supervisor. Using admission criteria approved by the Medical Staff, if the House Supervisor believes the patient's condition warrants a higher level of care than the level</p> <p style="text-align: right;">06/06/08</p>

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E1157	Continued From Page 3 considered potential candidates for admission to ICU; a) glucose greater than 500; b) CO2 less than 10, and; c) endocrine emergencies such as severe DKA requiring insulin infusion. During an interview with the Director of ICU/ED on June 6, 2008, at 12:25 p.m., the Director stated Patient 5 was, "mismanaged," in the ED. The Director stated, "All the signs were there, the patient was in DKA." She stated the patient should have been admitted to ICU.	E1157	Continued from Page 3 requested, the House Supervisor consults with the admitting physician to adjust level of care to be in compliance with hospital policies. Should there be any conflict between the House Supervisor and the admitting physician, the Chain of Command policy is utilized to resolve the issue. C. A description of the monitoring process and position of the persons responsible for monitoring. How facility plans to monitor its performance to ensure corrections are achieved and sustained. Using admission criteria approved by the Medical Staff, the Director of Critical Care Services reviews all patients upgraded to ICU status during the first 24 hours of hospitalization to determine if patients were admitted to the appropriate level of care. If the Director of Critical Care identifies a concern about the patient's initial level of care designation, the case is referred to the Medical Staff for additional review and action as appropriate. D. Dates when corrective action will be completed. • Corrective action initiated in June 2008 and maintained ongoing	06/06/08 Ongoing	
E1171	T22 DIV5 CH1 ART6-70495(d) Intensive Care Service Staff (d) There shall be not less than two nursing personnel physically present in the intensive care unit when a patient is present. At least one of the nursing personnel shall be a registered nurse. This RULE: is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure two nurses, trained and experienced in intensive care nursing, were physically present when ICU patients were present on the MST floor for one of one observed patients (Patient 5) and unobserved patients on 25 of 66 shifts reviewed, resulting in the potential for injury and death in patients on the MST floor requiring ICU care. Findings:	E1171	T22 DIV5 CH1 ART6-70495(d) Intensive Care Service Staff (ID Prefix tag E1171) Background Information: The CA DPH visit on April 18, 2008 resulted in misunderstanding. As a result of the April 18, 2008 visit the CNO and Critical Care Director did clearly understand that "ICU satelliting" was not permitted. However, neither understood the surveyor to state that two ICU competent nurses were required for care of medical-surgical patients who required an ICU bed when one was not available. In fact, staff understood the opposite. Discussion took place and the CNO and Critical Care Director specifically queried the surveyor in the presence of ICU staff nurses to clarify the requirement. Hospital staff all apparently misunderstood the surveyor's feedback, as they understood the surveyor to state that two nurses		

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According to CCR, Title 22, Section 70495(c) (regarding intensive care service staff), "All licensed nurses shall have training and experience in intensive care nursing."

1. During a tour of the MST floor on April 16, 2008, at 1:45 p.m., the staff at the nurses' station stated the block of rooms numbered 257, 258, 259, and 260 was the facility's, "satellite ICU."

During a concurrent interview with the CNO and the Director of ICU/ED on April 16, 2008, at 3:05 p.m., both stated the satellite ICU, located on the MST floor, was used to house ICU patients when the ICU was full. The CNO and the Director stated when there were one or two patients in the satellite ICU, there was one ICU nurse present to care for the patient(s). They stated the second, or backup, nurse was the CN on the MST floor. Both stated the MST CNs were not trained and experienced in intensive care.

The ICU census sheets were reviewed on April 16, 2008, to determine the activity of the satellite ICU on the MST floor. The sheets indicated the following:

- a) April 12, 2008, 7A-7P shift, two ICU patients with one ICU nurse;
- b) April 13, 2008, 7A-7P shift, two ICU patients with one ICU nurse, and;
- c) April 13, 2008, 7P-7A shift, two ICU patients with one ICU nurse.

The CNO and Director of ICU/ED were notified on April 16, 2008, at 3:05 p.m., the practice of having only one nurse who was trained and experienced in ICU physically present when there was an ICU patient was not in compliance

E1171 Continued from page 4

must be present and an ICU competent nurse must provide care to a patient requiring ICU level of care at the ratio appropriate to the needs of the ICU, that is, at a maximum ratio of one nurse to two patients.

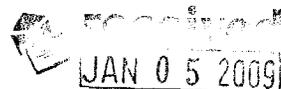
As a result of that visit, the Administration and Medical Staff leadership sent a letter to inform the general medical staff of the changes, as they were understood. These changes were that patients requiring ICU care were to remain in the physical location where they resided at the time an ICU bed was required but not available. Further, care would be provided by a registered nurse who was ICU competent.

Additionally, an ICU Resource Management Guideline was developed to assist staff in complying with the understood requirements. This document was provided to CA DPH to ensure there was complete agreement regarding the requirements in caring for ICU patients who were not physically in the ICU setting. Southwest Healthcare System did not receive different opinions or clarifying information stating the organization was not in compliance. Therefore, until June 6, 2008, Southwest Healthcare System followed the guidelines as had been set forth.

At all times, there were at least two nurses present in the units where a patient requiring ICU care resided and at all times one (in fact most) of the nurses were registered nurses. Therefore, it was the understanding that Southwest Healthcare System met or exceeded the requirement at all times.

A. What corrective action for patients identified to have been affected by deficient practice?
 • When the hospital was informed by the survey team of the interpretation of the rule, that there must be two ICU competent nurses present regardless of the location of the patient holding for an ICU bed, the Chief Nursing Officer (CNO)

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E1171 Continued From Page 5

with Title 22, and was a deficient practice. Both were notified the requirement was for two trained and experienced ICU nurses to be physically present when there was an ICU patient.

2. During a tour of the MST floor on June 6, 2008, at 7:10 a.m., the Director of MST stated the facility was no longer using the satellite ICU.

During an interview with the ICU CN on June 6, 2008, at 7:20 a.m., the CN stated if there were one or two patients on the MST floor needing ICU care, the facility staffed those patients with one ICU nurse. The CN stated she had never been on the MST floor alone with ICU patients, but she would not be comfortable without a second ICU nurse. The CN stated there was currently an ICU patient on the MST floor (as of 7 a.m.) because the patient, "went bad," on the floor and all of the ICU beds were full. The CN stated she sent one ICU nurse up to the floor to care for the ICU patient.

During an interview with the Director of ICU/ED on June 6, 2008, at 7:40 a.m., the Director stated the MST nurses were not trained and experienced in ICU.

The ICU census sheets were reviewed on June 6, 2008, to determine the continued activity of the satellite ICU on the MST floor. The sheets indicated the following:

a) May 2, 2008, 7A-7P shift, one ICU patient with one ICU nurse;

b) May 16, 2008, 7A-7P shift, one ICU patient with one ICU nurse;

c) May 16, 2008, 7P-7A shift, one ICU patient with one ICU nurse;

E1171 Continued from page 5

immediately provided a second ICU competent nurse to assist the primary ICU competent nurse caring for Patient #5 who was physically located on the medical-surgical unit. (The other patients listed in the report from prior admissions were provided care by an ICU competent nurse who was supported by the ICU Charge RN and the other RN's present on the medical-surgical unit.)

1. In agreement with on site surveyors from CA DPH the following actions were immediately put into place on 6/6/08 to address any potential patients that could be affected by the same deficient practice: 06/06/08

a. Patients requiring ICU level of care will be admitted to a licensed ICU bed.

b. When there is no bed available in the ICU, the following actions will be taken:

- A patient who presents to the Emergency Department and requires ICU level of care will be held in the Emergency Department until an ICU bed is available.
- A postoperative patient requiring ICU level of care will remain in the Post Anesthesia Care Unit (PACU) until an ICU bed becomes available.
- A patient on the Medical-Surgical Units whose clinical condition changes and requires ICU level of care will be held on the Medical-Surgical Unit until an ICU bed becomes available.

c. Staffing plan for patients requiring ICU level who are not physically located in the ICU is as follows:

- 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.
- When a Medical-Surgical patient's condition changes and requires an ICU level of care, two ICU nurses will be physically present on the unit. The appropriate nurse to patient ratio related to the ICU level of care is maintained.



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- d) May 17, 2008, 7A-7P shift, one ICU patient with one ICU nurse;
- e) May 17, 2008, 7P-7A shift, two ICU patients with one ICU nurse;
- f) May 18, 2008, 7A-7P shift, two ICU patients with one ICU nurse;
- g) May 18, 2008, 7P-7A shift, one ICU patient with one ICU nurse;
- h) May 19, 2008, 7A-7P shift, one ICU patient with one ICU nurse;
- i) May 19, 2008, 7P-7A shift, one ICU patient with one ICU nurse;
- j) May 20, 2008, 7A-7P shift, two ICU patients with one ICU nurse;
- k) May 20, 2008, 7P-7A shift, two ICU patients with one ICU nurse;
- l) May 21, 2008, 7P-7A shift, one ICU patient with one ICU nurse;
- m) May 22, 2008, 7A-7P shift, one ICU patient with one ICU nurse;
- n) May 22, 2008, 7P-7A shift, two ICU patients with one ICU nurse;
- o) May 23, 2008, 7A-7P shift, two ICU patients with one ICU nurse;
- p) May 25, 2008, 7P-7A shift, one ICU patient with one ICU nurse;
- q) May 26, 2008, 7A-7P shift, two ICU patients

E1171 Continued from page 6

B. How other patients having the potential to be affected by the same deficient practice will be identified, and what corrective actions will be taken.

1. In agreement with on site surveyors from CA DPH the following actions were immediately put into place on 6/6/08 to address any potential patients that could be affected by the same deficient practice:

a. Patients requiring ICU level of care will be admitted to a licensed ICU bed.

b. When there is no bed available in the ICU, the following actions will be taken:

- A patient who presents to the Emergency Department and requires ICU level of care will be held in the Emergency Department until an ICU bed is available.

- A postoperative patient requiring ICU level of care will remain in the Post Anesthesia Care Unit (PACU) until an ICU bed becomes available.

- A patient on the Medical-Surgical Units whose clinical condition changes and requires ICU level of care will be held on the Medical-Surgical Unit until an ICU bed becomes available.

c. Staffing plan for patients requiring ICU level who are not physically located in the ICU is as follows:

- 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.

- When a Medical-Surgical patient's condition changes and requires an ICU level of care, two ICU nurses will be physically present on the unit. The appropriate nurse to patient ratio related to the ICU level of care is maintained.

All patients requiring admission to the hospitals are reviewed for appropriate level of services by the House Supervisor. If the House Supervisor

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E1171	Continued From Page 7 with one ICU nurse; r) May 27, 2008, 7A-7P shift, two ICU patients with one ICU nurse; s) May 27, 2008, 7P-7A shift, two ICU patients with one ICU nurse; t) May 28, 2008, 7A-7P shift, two ICU patients with one ICU nurse; u) May 29, 2008, 7P-7A shift, one ICU patient with one ICU nurse, and v) May 30, 2008, 7A-7P shift, one ICU patient with one ICU nurse. 3. During a tour of the MST floor on June 6, 2008, at 7:55 a.m., Patient 5 was observed in a MST bed with one nurse (RN 1) assigned to care for her. The patient was pale in color with rapid, labored respirations in a Kussmaul pattern (very deep and labored breathing found among people with severe acidosis), and facial grimacing. A review of the record indicated Patient 5, a 36 year old female, presented to the ED on June 5, 2008, at 11:15 p.m., with a complaint of diabetes with a high blood sugar and vomiting. According to the ED record, labs done at 12:05 a.m. showed a CO2 of 7 (normal 22-26), and an initial blood sugar of 376 (the facility normal range was 70-105). The patient's blood sugar at 3:50 a.m. had increased to 504. Patient 5 was admitted to the MST floor at 4:30 a.m. The record indicated on arrival to the MST floor. Patient 5 had labored respirations at a rate of 32/minute. At 6:40 a.m., lab results indicating DKA (a metabolic disorder characterized by high	E1171	Continued from Page 7 feels the patient's condition warrants a higher level of care than the level requested, the House Supervisor consults with the admitting physician to adjust level of service to be in compliance with hospital policies. Should there be any conflict between the House Supervisor and the admitting physician, the Chain of Command policy is utilized to resolve the issue. C. What immediate measures and systematic changes will be put into place to ensure that the same deficient practice does not recur? 1. In agreement with on site surveyors from CA DPH the following actions were immediately put into place on 6/6/08 to address any potential patients that could be affected by the same deficient practice: a. Patients requiring ICU level of care will be admitted to a licensed ICU bed. b. When there is no bed available in the ICU, the following actions will be taken: - A patient who presents to the Emergency Department and requires ICU level of care will be held in the Emergency Department until an ICU bed is available. - A postoperative patient requiring ICU level of care will remain in the Post Anesthesia Care Unit (PACU) until an ICU bed becomes available. - A patient on the Medical-Surgical Units whose clinical condition changes and requires ICU level of care will be held on the Medical-Surgical Unit until an ICU bed becomes available. c. Staffing plan for patients requiring ICU level who are not physically located in the ICU is as follows: - 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.

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E1171	Continued From Page 8 blood sugar, high respiratory rate, low carbon dioxide, and low blood pH) were called to the physician, and an insulin drip (continuous infusion of a medication to lower the blood sugar) was ordered (requiring ICU care). During an interview with RN 1 on June 6, 2008, at 7:55 a.m., the RN stated she was assigned to care for Patient 5, and she was the only ICU trained nurse on the floor. RN 1 stated, "It would be nice to have two nurses. Sometimes I have to stand by the door and yell out to get somebody to help me." RN 1 stated if she had an ICU emergency, the medications and supplies on the MST unit were different than the medication and supplies in ICU, and the nurses were not ICU trained, so she would call for the ICU charge nurse and, "hope she was available." RN 1 stated she did not like walking away from her patients to get medications and supplies because "nobody" was there to watch her patients like they were in the ICU. The COO, Assistant CNO, and Director of PI were notified Immediate Jeopardy was identified on June 6, 2008, at 9:05 a.m. The Immediate Jeopardy was identified due to the facility's failure to ensure the physical presence of two ICU trained and experienced nurses on the MST floor when there was an ICU patient present. The facility developed a plan of correction that included the following: a) Placing an additional ICU nurse on the MST floor where the ICU patient resided; b) Changing the staffing plan to include two ICU nurses on the MST floor when the status of a current patient changed to require an ICU level of care, and;	E1171	Continued from Page 8 - When a Medical-Surgical patient's condition changes and requires an ICU level of care, two ICU nurses will be physically present on the unit. The appropriate nurse to patient ratio related to the ICU level of care is maintained. D. A description of the monitoring process and position of the persons responsible for monitoring. How facility plans to monitor its performance to ensure corrections are achieved and sustained. • The Chief Nursing Officer (CNO) is responsible for monitoring compliance. Ongoing • 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 tracking form that, coupled with the staffing sheets, ensure adequate competent ICU staffing levels are maintained at all times. Ongoing • The Director of Critical Care Services reviews all patients whose status changes to a higher level of care during hospitalization to ensure patients have been placed at the appropriate level of care. Ongoing E. Dates when corrective action will be completed. • Corrective action related to placement and staffing completed and sustained as of 6/6/08. 06/06/08 • Corrective action related to reviewing all patients with status changes initiated in June 2008 and ongoing review occurs monthly. Ongoing		

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E1171 Continued From Page 9

E1171 Continued from Page 9

c) Educating the HS, ICU and MST staff regarding the staffing requirements.

Implementation of the plan of correction was verified on June 6, 2008, at 10:55 a.m., with observation of two ICU trained and experienced nurses physically present on the MST floor where the ICU patient was located. The Director of PI and the COO were notified the Immediate Jeopardy was abated on June 6, 2008, at 11:15 a.m.

E2278 T22 DIV5 CH1 ART8-70805 Space Conversion

E2278 T55 DIV5 CH1 ART8-70805 Space Conversion

Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of the Department.

This RULE: is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to prevent the conversion of MST beds to ICU beds, by admitting ICU patients to the MST floor for ICU care, for four of four patients observed in the satellite ICU (Patients 1, 2, 3, and 4) and unobserved patients on five of 66 shifts reviewed, resulting in the use of space for a purpose other than what it was licensed for, and the potential for injury and death to patients admitted to the MST telemetry floor for ICU care.

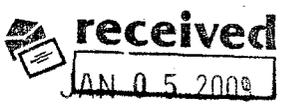
Findings:

1. During a tour of the MST floor on April 16, 2008, at 1:45 p.m., the staff at the nurses' station stated the block of rooms numbered 257, 258, 259, and 260 was the facility's, "satellite ICU."

Background Information:

The CA DPH visit on April 18, 2008 resulted in misunderstanding. As a result of the April 18, 2008 visit the CNO and Critical Care Director did clearly understand that "ICU satelliting" was not permitted. However, neither understood the surveyor to state that two ICU competent nurses were required for care of medical-surgical patients who required an ICU bed when one was not available. In fact, staff understood the opposite. Discussion took place and the CNO and Critical Care Director specifically queried the surveyor in the presence of ICU staff nurses to clarify the requirement. Hospital staff all apparently misunderstood the surveyor's feedback, as they understood the surveyor to state that two nurses must be present and an ICU competent nurse must provide care to a patient requiring ICU level of care at the ratio appropriate to the needs of the ICU, that is, at a maximum ratio of one nurse to two patients.

As a result of that visit, the Administration and Medical Staff leadership sent a letter to inform the general medical staff of the changes, as



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E2278	<p>Continued From Page 10</p> <p>Observation of the area revealed two ICU nurses were present with four patients who had been in the rooms as ICU patients, but had been down graded to MST patients that day;</p> <p>a) Patient 1, an 88 year old female, was admitted from the ED to the MST floor (for ICU care) with a low hemoglobin (measurement of oxygen carrying blood cells), requiring blood transfusions;</p> <p>b) Patient 2, a 19 year old male, was admitted from the PACU to the MST floor (for ICU care) after repeated craniotomies (brain surgeries) to revise a shunt (a device used to enhance drainage of fluid);</p> <p>c) Patient 3, an 88 year old female, was admitted from the ED to the MST floor (for ICU care) with an AMI (heart attack), requiring cardiac care and monitoring, and;</p> <p>d) Patient 4, a 44 year old male, was admitted from the ED to the MST floor (for ICU care) with a GI bleed, requiring a procedure to stop the bleeding.</p> <p>During a concurrent interview with the CNO and the Director of ICU/ED on April 16, 2008, at 3:05 p.m., both stated the ICU satellite, located on the MST floor, was used to house ICU patients when the ICU was full.</p> <p>The ICU census sheets were reviewed on April 16, 2008, to determine the activity of the satellite ICU on the MST floor. The sheet dated April 13, 2008, 7A-7P shift, indicated the following;</p> <p>a) one patient was admitted from the ED to the MST floor for ICU care, and;</p>	E2278	<p>Continued from Page 10</p> <p>they were understood. These changes were that patients requiring ICU care were to remain in the physical location where they resided at the time an ICU bed was required but not available. Further, care would be provided by a registered nurse who was ICU competent.</p> <p>Additionally, an ICU Resource Management Guideline was developed to assist staff in complying with the understood requirements. The guidelines included assessment of patients and direction for moving a less acute ICU patient to a non-ICU area in the event that a severely critically ill patient needed the resources only available in the physical ICU setting. This document was provided to CA DPH to ensure there was complete agreement regarding the requirements in caring for ICU patients who were not physically in the ICU setting. Southwest Healthcare System did not receive different opinions or clarifying information stating the organization was not in compliance. Therefore, until June 6, 2008, Southwest Healthcare System followed the guidelines as had been set forth.</p> <p>At all times, there were at least two nurses present in the units where a patient requiring ICU care resided and at all times one (in fact most) of the nurses were registered nurses. Therefore, it was the understanding that Southwest Healthcare System met or exceeded the requirement at all times.</p> <p>A. What corrective action for patients identified to have been affected by deficient practice?</p> <p>1. Until 6/6/08 the facility understood that the CA DPH approved of all aspects of Resource Management Guidelines that were in affect. However, on 6/6/08, upon notification of deficient practice, the Resource Management Guidelines immediately changed to remove the portion that allowed for triaging lower acuity ICU level patients when higher acuity ICU patients presented.</p> <p>06/06/08</p>

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E2278	Continued From Page 11 b) one patient was transferred from ICU bed five to the MST floor (still needing ICU care) so a neurosurgical patient could be admitted to ICU bed five from PACU. The CNO and Director of ICU/ED were notified on April 16, 2008, at 3:05 p.m., the practice of converting MST space (beds) to ICU space (beds) was not in compliance with Title 22, and was a deficient practice. Both were notified they could no longer admit ICU patients to the MST floor, as the beds were not licensed for ICU. 2. During a tour of the MST floor on June 6, 2008, at 7:10 a.m., the Director of MST stated the facility was no longer using the ICU satellite. During an interview with the ICU CN on June 6, 2008, at 7:20 a.m., the CN stated any time the ICU beds were full and a neurosurgery patient needed an ICU bed, patients would be moved out of ICU to the medical surgical floor (still needing ICU care), and the neurosurgical patient would be moved into the ICU. The ICU census sheets were reviewed on June 6, 2008, to determine the continued activity of the "satellite ICU" on the MST floor. The sheets indicated the following: a) on May 17, 2008, during the 7P-7A shift, a patient was admitted from the PACU to the MST floor for ICU care; b) on May 20, 2008, during the 7P-7A shift, a patient was admitted from the ED to the MST floor for ICU care. and; c) on May 27, 2008, during the 7A-7P shift, a patient was transferred from ICU bed seven to the MST floor (still needing ICU care) so a	E2278	Continued from Page 11 Effective 6/6/08, in agreement with on site surveyors from CA DPH the following actions were immediately put into place: a. Patients requiring ICU level of care will be admitted to a licensed ICU bed. b. When there is no bed available in the ICU, the following actions will be taken: - A patient who presents to the Emergency Department and requires ICU level of care will be held in the Emergency Department until an ICU bed is available. - A postoperative patient requiring ICU level of care will remain in the Post Anesthesia Care Unit (PACU) until an ICU bed becomes available. - A patient on the Medical-Surgical Units whose clinical condition changes and requires ICU level of care will be held on the Medical-Surgical Unit until an ICU bed becomes available. - The ICU Resource Management Guidelines were immediately revised removing the direction to assess acuity and move patients requiring ICU care. B. How other patients having the potential to be affected by the same deficient practice will be identified, and what corrective actions will be taken. a. Patients requiring ICU level of care will be admitted to a licensed ICU bed. b. When there is no bed available in the ICU, the following actions will be taken: - A patient who presents to the Emergency Department and requires ICU level of care will be held in the Emergency Department until an ICU bed is available. - A postoperative patient requiring ICU level of care will remain in the Post Anesthesia Care Unit (PACU) until an ICU bed becomes available. - A patient on the Medical-Surgical Units whose clinical condition changes and requires ICU level of care will be held on the Medical-Surgical Unit until an ICU bed becomes available.	06/06/08

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E2278 Continued From Page 12

neurosurgical patient could be admitted to ICU bed seven from PACU.

A facility document titled, "Resource Management for ICU Patients," was reviewed on June 6, 2008. The document indicated when a patient needing admission to the ICU required complex ICU monitoring, a patient of lower acuity already in the ICU would be moved to the MST floor for ICU care.

A written cease and desist 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 MST beds to ICU beds.

A plan of correction was received on June 6, 2008, at 2:52 p.m. The plan indicated patients requiring ICU care would only be admitted to a licensed ICU bed. The PI Director was notified the plan was accepted at 2:55 p.m.

E2278

Continued from page 12

C. What immediate measures and systematic changes will be put into place to ensure that the same deficient practice does not recur?

- a. Patients requiring ICU level of care will be admitted to a licensed ICU bed.
- b. When there is no bed available in the ICU, the following actions will be taken:
 - A patient who presents to the Emergency Department and requires ICU level of care will be held in the Emergency Department until an ICU bed is available.
 - A postoperative patient requiring ICU level of care will remain in the Post Anesthesia Care Unit (PACU) until an ICU bed becomes available.
 - A patient on the Medical-Surgical Units whose clinical condition changes and requires ICU level of care will be held on the Medical-Surgical Unit until an ICU bed becomes available.
- c. On a daily basis the House Supervisor tracks ICU patients. Should there be patients outside of the ICU, no additional elective patients requiring ICU are admitted until all patients are absorbed into the ICU unit.

D. A description of the monitoring process and position of the persons responsible for monitoring. How facility plans to monitor its performance to ensure corrections are achieved and sustained.

1. The Chief Nursing Officer (CNO) is responsible for monitoring compliance. Ongoing
2. 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 staffing sheets, ensure the following: Ongoing
 - a. Appropriate ICU staffing levels are maintained at all times, and
 - b. Appropriate utilization of space is maintained in that a bed licensed for general acute care will not be converted for ICU care by admitting an ICU patient to a medical-surgical bed.



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E2278	Continued From Page 12 neurosurgical patient could be admitted to ICU bed seven from PACU. A facility document titled, "Resource Management for ICU Patients," was reviewed on June 6, 2008. The document indicated when a patient needing admission to the ICU required complex ICU monitoring, a patient of lower acuity already in the ICU would be moved to the MST floor for ICU care. A written cease and desist 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 MST beds to ICU beds. A plan of correction was received on June 6, 2008, at 2:52 p.m. The plan indicated patients requiring ICU care would only be admitted to a licensed ICU bed. The PI Director was notified the plan was accepted at 2:55 p.m.	E2278	Continued from page 13 E. Dates when corrective action will be completed. • Daily tracking of ICU patients initiated and ongoing since 6/6/08. 06/06/08 and Ongoing

