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SOUTHWEST HEALTHCARE SYSTEM	25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562

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A 000	INITIAL COMMENTS The following reflects the findings of the California Department of Health Services during a Complaint Validation Survey (complaint numbers 115208 and 116136) authorized by the Centers for Medicare and Medicaid Services (CMS), Region IX. The Southwest Healthcare System is comprised of two hospitals, Inland Valley Medical Center (IVMC) and Rancho Springs Medical Center (RSMC). The survey was conducted at IVMC on May 30 and 31, 2007, and concluded at RSMC on June 1, 2007. On May 30, 2007, at 2:35 PM, Immediate Jeopardy was identified regarding the Condition of Participation: Emergency Services. IVMC and RSMC are under one provider number and share administrative, medical and nursing staff. It was determined that the same conditions existed at IVMC and RSMC, so the Immediate Jeopardy included both facilities. The Immediate Jeopardy was not abated by the survey exit date of June 1, 2007. Representing the Department: Tina Buchanan, HFEN; Carolyn McHugh, HFEN; and Morton Kligerman, MD, MPH, Medical Consultant.	A 000	By submitting this plan of correction, the Hospital does not agree that the citations are correct or that it violated the rules. Please see credible allegation of compliance following each description of corrective action the Hospital has taken to address the concerns of the surveyors.	
A 006	482.12 GOVERNING BODY 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.	A 006	Please note that this report contains citations that are similar to those contained in the CMS 2567 issued on June 13, 2007. The corrective actions implemented in response to that plan of correction were reviewed and accepted by California surveyors on July 13, 2007.	

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

CEO/MANAGING DIRECTOR 8/27/07

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.

ACCEPTABLE

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A 006	Continued From page 1 This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the Governing Body had full legal responsibility for the conduct of the facility, including all services offered. The Governing Body failed to ensure that: 1. The Medical Staff operated under the current medical staff bylaws, rules and regulations as approved by the Governing Body with regard to on-call physician services (A011); the Medical Staff was accountable to the Governing Body for the care provided to patients in the Emergency Department (ED) and Intensive Care Unit (ICU) (A012); and, the Chief Executive Officer maintained full responsibility for managing the facility (A015). 2. Following a major change from mandatory to voluntary provision of on-call physician services, the facility's Quality Assurance and Performance Improvement program failed to collect and analyzed data that tracked quality indicators, including adverse patient events, and other aspects of performance that assessed the processes of care and facility services, especially for the ED and ICU (A145); collect and use data to monitor the effectiveness and safety of instituting a voluntary call panel for some specialties(A0148); specify the frequency and detail of the data collected to monitor the trail of voluntary call (A0150); Ensure that the hospital-wide QAPI efforts addressed priorities for improved quality of care, all improvement actions were evaluated and adequate resources were allocated for QAPI activities. (A0167); and, Ensure that the QAPI program monitored the safety of patients during the trial of voluntary call (A0169).	A 006	Virtually all the citations in this deficiency statement relate to the provision of emergency services in terms of what services are available through the list of physicians who are on call to provide emergency services; what review was done concerning the determination of which specialties are available through the on call list; the involvement of the Governing Body, Administration, and the Medical Staff in the establishment of the on call list; and the enforcement of on-call responsibilities if an on-call physician does not respond in a reasonable time or as requested by the Emergency Department (ED). Southwest Healthcare System would like to clarify that all physicians who participate in the call roster are obligated to respond when requested by the ED. Through conversations with California Department of Health Services staff after the June 1, 2007 survey was completed, Southwest Healthcare System realized that the surveyors misunderstood the obligations of physicians taking call for the ED. While participation in the on-call list is voluntary for members of the medical staff, once a physician volunteers to provide on-call coverage for the ED, the physician is obligated to respond and may be disciplined for failure to respond to a call. It appears that the surveyors thought that the on-call physicians were not obligated to respond to the ED, and because of that the deficiencies were cited. The Governing Body of Southwest Healthcare System has been actively	

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A 006	Continued From page 2 3. The Medical Staff members were accountable to the Governing Body for the provision of on-call physician coverage for the Emergency Department and Intensive Care Unit for specialty medical services that were provided by the facility (A0185) and the Medical Staff enforced its adopted bylaws to ensure that the responsibilities of all the Medical Staff members were carried out (A0186). 4. The Medical Staff provided ongoing and continuing assessment of the medical care provided in the ED, to establish and/or revise policies and procedures governing the ED medical care, based on Quality Assurance and Performance Improvement (A0456) and, there was adequate on-call physician coverage for patients in need of specialized treatment when the facility had the capacity to treat the individual (A0459). The cumulative effect of this systemic problem resulted in the failure of the Governing Body to ensure that patients received quality medical care in a safe patient environment.	A 006	involved in reviewing the provision of emergency services provided by Southwest Healthcare System, including which services are necessary to meet the emergency needs of the community the hospital serves. Significantly, the relatively low rate of transfers from the ED to other hospitals did not change with the implementation of the voluntary call system. Nevertheless, the Governing Body and Administration continue to review emergency services and transfers, and the Governing Body is authorizing Administration to make changes to the provision of hospital services that may result in a decrease in the need for transfers of emergency patients (e.g., addition of 44 beds at the Inland Valley campus and the development of an interventional cardiology program and neonatal intensive care unit (NICU)). These actions are discussed in more detail below. See responses to the tags below for information concerning actions taken.	
A 011	482.12(a)(4) MEDICAL STAFF - BYLAWS AND RULES The governing body must approve medical staff bylaws and other medical staff rules and regulations. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the medical staff was operating under current bylaws, rules and regulations that were approved by the governing	A 011	This tag quotes provisions from the Medical Staff Bylaws and Rules and Regulations, while mixing up those that apply on the inpatient side and those that apply to ED call coverage. Likewise, the examples cited are a mix of examples of inpatients and ED patients, and physician responsibilities differ depending on whether the patient is admitted or in the ED. The Bylaws and Rules and Regulations state clearly that physicians who admit patients to the hospital are responsible for responding promptly to calls about their	

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A 011	Continued From page 3 board, in regard to physician on-call services by specialists with active and provisional privileges at the facility, for 11 of 62 patients at IVMC (Patient 135, 201, 202, 105, 118, 119, 120, 121, 122, 124 and 129), and eight of 70 patients at RSMC (Patient 44, 31, 36, 40, 203, 204, 205 and 206). Findings at IVMC: On May 30, 2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated the practice for the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the Governing Body initially approved the voluntary call system on a trial basis for 90 days, and subsequently extended the trial time on two separate occasions. The current on-call physician coverage for the facility was voluntary. The meeting minutes for the Family Practice Department were reviewed on May 30, 2007. In the minutes dated November 29, 2006, there was a report by Emergency Department (ED) Physician B for ED Physician C, that advised, "Since call is currently voluntary, written agreements are currently in progress by administration for specialists. We currently do not have a formal call panel for Neurology, ENT, Pulmonology, and Ophthalmology, causing patients to be transferred. The minutes for March 2007, were also reviewed. In the first paragraph of the executive session was the statement, "The department noted that neurosurgeons have the choice to respond or not to a consult request."	A 011	patients or arranging for coverage when they are unavailable. With respect to the ED, although physicians have discretion about volunteering to participate on the ED call list, once they agree to take call for the ED, they must respond and come in when requested. PLAN OF CORRECTION REGARDING INPATIENTS Administration reviewed and confirmed that the Bylaws and Rules and Regulations had been revised and approved in February 2007. Administration reviewed and identified several provisions, such as Rule section 2.1.1, that retained some language about ED coverage being an obligation of all medical staff members. The Governing Body reviewed section 2.1.1 and clarified how such a provision should be interpreted in light of the decision to make participation on the ED call list voluntary. The Governing Body forwarded the interpretation to the Medical Executive Committee (MEC) for review and consideration of revision when the Rules and Regulations are next amended. The Governing Body issued a letter to all Medical Staff members emphasizing the interpretation of Rule section 2.1.1. that participation on the ED call panel may be voluntary, but that any physician serving on the call panel is obligated to respond.	07/13/07 07/13/07 07/16/07 08/03/07

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A 011	Continued From page 4 On May 30, 2007, the Medical Staff Bylaws, that were revised on February 22, 2007, were reviewed. The Bylaws specified, "Each active medical staff member shall...Actively participate on, and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including but not limited to emergency services and back-up functions....Provisional staff members seeking Active staff membership shall participate in emergency services and back-up functions." On May 30, 2007, a review of the current Medical Staff Rules and Regulations, that were revised May 22, 2006, showed that: a. Section 1.3.2; "Each practitioner must be available to provide professional care for his/her patients in a timely manner (30 minutes) or arrange for an alternate practitioner who has equivalent clinical privileges at the hospital." b. Section 2.1.1; "A call panel has been established for referring patients who need hospital care to qualified medical staff members. Service on the call panel is not a privilege, but is an obligation of staff membership." c. Section 2.2.1; "Practitioners on call must respond promptly when requested to see a patient. Practitioners, including specialty consultants, must respond initially by phone or in person within approximately 30 minutes of the time the request to respond is made." d. Section 2.2.3; "When scheduled on call, each practitioner shall accept the care of all patients who are appropriately referred..."	A 011	The Governing Body reviewed the CMS Conditions of Participation requirements, Interpretive Guidelines, and survey procedures concerning Medical Staff Bylaws. The Hospital Governing Body and MEC leadership reviewed and confirmed that physicians who admit their patients to the Hospital must be available to provide care for their patients in a timely manner or arrange for an alternate practitioner who has equivalent clinical privileges at the Hospital. The Hospital Governing Body and MEC leadership reviewed and confirmed that participation on the call panel for the ED is not mandatory at this time, but that when a physician agrees to participate on the call panel and is on call for the ED, the physician MUST respond to the Hospital timely when called, MUST come to the Hospital timely to render care when requested, and MUST see all unassigned patients as requested. The Hospital Governing Body and MEC reviewed and confirmed the Medical Staff Bylaws provisions regarding the timeframe for responding to calls from the Hospital regarding the emergency needs of patients (both inpatients and ED patients): --Physicians with admitted patients must respond timely (within 30 minutes) or arrange for another comparable physician to take call and respond timely, AND --Physicians on call for the ED must respond by phone or in person within 30	06/18/07 06/18/07 06/18/07 06/18/07

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A 011	Continued From page 5 e. Section 2.2.4; "The on call specialist must also be available for inpatients. If no other specialist in that specialty is willing or able to provide care for a particular inpatient, the on call specialist has the obligation to see that patient to treat, stabilize or appropriately transfer the patient in a timely manner." f. Section 2.2.7; "A patient will be admitted in the name of the call panel practitioner. The call panel practitioner must be notified about each admission to his service prior to the patient leaving the Emergency Department, and following a discussion with the Emergency Department physician." The medical record for Patient 135 was reviewed on May 30, 2007. Patient 135, a 66 year old male, was admitted to the Intensive Care Unit (ICU) on May 29, 2007, after an emergency tracheostomy (a tube into the trachea for breathing) was performed in the ED. On the "I.C.U./P.C.U. Flow Sheet", dated May 29, 2007, at 9:30 PM, the nurse documented that Patient 135 became agitated and was fighting the ventilator (breathing machine). The nurse also documented that the patient's attending physician and the pulmonologist were paged for assistance and there was no return call from either physician. During an interview with ICU RN 1 on May 30, 2007, at 9:50 AM, she stated that the pulmonologists took call for their own patients during the week, and the on-call pulmonologist covered on the weekends. When she was asked what they did when there was no pulmonologist on call due to the "voluntary" call system, she stated that they called the ED to see if there was	A 011	minutes, and must come to the Hospital within 30 minutes to render care when asked to do so. When the on-call physician has responded first by telephone, he/she can give direction/orders for testing or interventions (as appropriate) while the physician is traveling to the Hospital. The Medical Staff members of the Governing Board drafted and circulated a letter to all Medical Staff members reminding them that they must respond at least by telephone to calls from Hospital staff about their inpatients, and when they are on call for the ED, they must respond by telephone or in person to calls from the ED within 30 minutes, and must come to the ED within 30 minutes when requested. The letter was mailed, faxed, placed in physicians' mailboxes, and posted in all physician areas at both Hospital campuses. The Governing Body approved the recommendations of the Department of Medicine and of the MEC to grant the requests of several internal medicine physicians for additional privileges to manage ventilator patients. As part of this recommendation and approval process, the Department of Medicine, the MEC, and the Governing Body reviewed the categories of physicians allowed to hold ventilator management privileges at multiple hospitals in the surrounding areas. Additionally, these groups recognized that privileges were appropriate for physicians whose scope of practice encompasses this area of patient care management, and that ventilator management is by far the most common emergent need associated with pulmonary care.	06/21/07 06/18/07

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A 011	Continued From page 6 somebody on call, and if not, they called all of the pulmonologists on staff until they found one that was available to help them. During an interview with the Chief Nursing Executive (CNE) on May 30, 2007, at 11:50 AM, the CNE stated that she received complaints from the nursing staff about the physicians not being available when the nurses called them. The CNE said the complaints were becoming "slightly more" in the ED, and "noticeably more" in the ICU. The CNE stated that there was no particular day of the week, time of day, or specialty that was complained about more. She stated it seemed to be more of an "individual person problem." The CNE declined to give names of the physicians the nursing staff complained about. Further review of the Medical Staff Bylaws (revised 5/22/06) on May 30, 2007, at 3:15 PM. showed that: a. Section 3.7; "Each member of the medical staff shall retain responsibility, within his or her area of professional competence, for the continuous care and supervision of each patient in the hospital for whom he or she is providing services, or arrange for a suitable alternative to assure such care and supervision." b. Section 4.2.3; "Each active Medical Staff Member shall actively participate on and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including, but not limited to emergency services and back-up functions ... c. Section 10.5.3; "A supervisory (departmental) committee shall conduct patient care reviews for	A 011	--These physicians had demonstrated competency and submitted their requests for additional privileges before the survey took place. --The granting of these additional privileges increased the pool of consultants available to provide assistance with ventilator management, to take call in this area and to be available to Hospital Administration and Medical Staff leadership if nursing staff invokes the chain of command to address a patient's sudden change in condition. Administration and ED Physician Leadership revised the on-call roster for the ED so that a pulmonologist or internist privileged to manage patients on ventilators was on call almost 24/7 for the next month, with the goal of providing ventilator management coverage 24/7, 365 days a year going forward. Administration reviewed and confirmed the Hospital has an effective process for obtaining timely assistance from physicians for inpatients with emergency needs: --As has long been the standard of practice, attending physicians direct the care of their patients and are responsible for obtaining consults by specialists, as they deem necessary, and for arranging coverage for themselves when they are not available. If an inpatient has an emergency, the nursing staff first calls the attending physician or the physician covering for the attending.	07/03/07 06/18/07

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A 011	Continued From page 7 the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department." d. Section 10.8.5; The duties of department chairs include, "Generally monitor the quality and appropriateness of patient care and professional performance provided by members with clinical privileges in the department ...and oversee the effective conduct of patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee," and also, "enforce Medical Staff Bylaws, Rules and Regulations and policies within the department ..." and, "provide for continuous assessment and improvement of the quality of care and services provided." The Performance Improvement Committee shall, "establish systems to identify potential problems in patient care and general areas of potential risk in clinical aspects of patient care and safety." Further review of ICU medical records on May 30, May 31 and June 1, 2007, at IVMC, showed the following: a. Patient 201, a 76-year-old male was admitted to the ICU on May 24, 2007, with a preliminary diagnosis of Epidural Abscess (collection of pus near the spinal cord). A neurology consultation, dated May 24, 2007, was handwritten in the physician's progress notes. A transcribed, dictated and very detailed neurology consultation was in the medical record, also dated May 24,	A 011	--Other physicians already consulting on the patient's treatment team are likewise obligated to respond if called and to provide coverage for themselves. --As a backup in an emergency, there is an ED physician in-house at each hospital, 24/7, 365 days a year. --As further backup, if there is a need for a specialist not already consulting on the case, the nursing staff may contact the appropriate physician on the on-call panel for the ED if one is on the schedule, because as the 2567 notes, section 2.2.4 of the Medical Staff Rules states that assisting with inpatient emergencies is a requirement for any physician while on call for the ED. --Because there may be occasions when there is not on-call coverage for the ED in the desired specialty, there is a need for a specialty consultant to address an emergency, and the attending physician has not found a consultant, the nursing staff can run the chain of command to get medical staff assistance with finding a consultant. --As a final and rare option, the Hospital may arrange to transfer the patient to another facility that can address the patient's problem.	

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A 011	Continued From page 8 2007. The transcribed consultation note was identified as being performed by Physician A. At the end of the dictated consultation, Physician A noted that he would be going out of town, and had notified the admitting physician. b. Patient 202, an elderly gentleman with left-sided weakness and pneumonia was hospitalized in ICU at IVMC during the time of survey. On May 31, 2007, at 8:15 AM, Patient 202 suffered a deterioration of his respiratory status. The nurses notes contained the timeline of events. Physician H, a neurologist, was at the bedside of Patient 202 when the nurses called Physician F, a Pulmonologist/Intensivist, also Medical Director for Respiratory Services, for assistance with an emergency intubation (placement of a breathing tube into the lungs). According to the nurses notes, Physician F was unavailable to come to the hospital. The nurses then paged Physician I to assist with an emergency intubation. Physician I is also a Pulmonary/Critical Care specialist, although he was not listed on the on-call schedule. The nurses informed Physician I that the patient required emergency intubation, but he was unavailable to come to the hospital at that time. A code blue (patient needing resuscitation team) was called and physician J, an ED physician, responded and intubated the patient at approximately 9:05 AM, 50 minutes after the patient was identified to be in severe respiratory distress requiring mechanical ventilation (breathing machine). During an interview with the Director of ICU on May 31, 2007, at 10:20 AM, she stated that she got feedback, from the nurses, for all of the problems that arose in the ICU. According to the	A 011	Administration reviewed and confirmed the Hospital has an effective process for enforcing these requirements. The chain of command assists the nursing staff in responding to the needs of patients, and the reporting and monitoring system is the tool for enforcing the Bylaws provision as follows: --When a physician does not respond timely to a page and the nurses have to run the chain of command as necessary to meet an urgent patient care need, they are supposed to generate a Healthcare Peer Review Report (HPRR). --The information in the HPRR goes to the physician's Department Chair to address with the physician informally. --The information in the HPRR is also kept for tracking purposes and for consideration during the physician's recredentialing process. --If a physician shows a trend of slow response to pages, then the Hospital holds a formal meeting with the physician to discuss the problem and corrective action, and the physician is monitored after that for a period of time to be sure there are no further delays in responding to pages. Department Managers/Directors reviewed with nursing staff members and Respiratory Care Professionals the process for running the chain of command and generating an HPRR when a physician does not respond timely to an emergency.	06/18/07 06/29/07

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A 011	Continued From page 9 Director, the ICU nurses were having a great deal of difficulty getting a pulmonologist to assist with ventilator management up until approximately two months ago. The Director stated with the addition of a new pulmonologist, the problem had improved. She stated she received approximately two calls per month from the ICU nursing staff related to this problem. She stated that when the ICU staff needed to know who was on call for a specialty, they usually knew by "word of mouth." If not, they called the ED for information. If the ED could not help, they called the offices for that particular specialty and inquired. If the offices didn't know, they went "down the list" and called all of the physicians in that specialty to see if they could get assistance. If they were still unable to get a specialist, they called the ICU Medical Director. The ICU Director stated that when the nursing staff had a delay in getting a response from a physician, they were supposed to write an HPRR (Healthcare Peer Review Report), that was reviewed and investigated by the clinical lead, and forwarded to the Performance Improvement Department. The ICU staff meeting minutes, dated April 19, 2007, were reviewed on May 31, 2007, at 10:50 AM. Under Department Issues, there was a discussion regarding "nurse apathy". The first causative factor of nurse apathy was listed as "MD's do not seem to have accountability, do not answer pages, pass the buck, change phone numbers constantly". During an interview with ICU RN 2 on May 31, 2007, at 11:05 AM, ICU RN 2 stated that she remembered the April 19 staff meeting when the physician accountability was discussed. ICU RN 2 stated that if they need a specialist, they usually	A 011	Administration confirmed that training on the chain of command is also included in each annual competency update that all staff members complete. The Risk Management Department is responsible for monitoring HPRRs to determine whether any physician shows a trend of delay in response to calls from the Hospital. Risk Management reports to the PI/RM Committee, which reports as appropriate to the MEC and Governing Body. The Department of Medicine met and discussed methods for making it more efficient for nursing staff to reach the physicians with calls about inpatients. The Chair of the Department of Medicine is responsible for notifying all members of the Department about how to make it easier for the Hospital nursing staff to reach them when calling about inpatients under their care. The CNE is responsible for updating the intranet phone list that nurses use to contact physicians so that the list reflects the changes the physicians are making to enable nursing staff to reach them more quickly and easily. The CNE provided reminder education to nursing staff, and particularly to ICU nursing staff, about calling codes promptly what a patient becomes emergent.	06/29/07 06/29/07 & ongoing 08/01/07 08/31/07 09/15/07 08/30/07

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A 011	Continued From page 10 "just know who to call". If they did not know, ICU RN 2 stated, "we sometimes have to call all of the doctors on the list for that specialty". She stated that the problem had not improved yet. During an interview with ICU RN 3 on May 31, 2007, at 11:15 AM, ICU RN 3 stated that she remembered the April 19 staff meeting where the physician accountability was discussed. ICU RN 3 stated that the problem was worse for the night shift, and on the weekends. She stated that the nurses got tired and frustrated, and "we just want to take care of our patients, and the doctors don't care". ICU RN 3 stated that she had completed HPRR's regarding her inability to reach the physicians. The Director of Respiratory Services was interviewed on May 31, 2007 at 3:25 PM. He stated that in the event a patient on a ventilator needed a change in the machine settings, the pulmonologist on call would be contacted. If there was no pulmonologist on call, or if there was no response to a page, the respiratory therapist would call their Medical Director, Physician F. Physician F is board certified in Pulmonology and in Critical Care. If he was not available, then the "chain of command" was initiated. During a review of ED medical records at IVMC on May 30 and May 31, 2007, the following was noted: a. Patient 105, a 77 year old female, presented to the ED on March 2, 2007, at 12:36 PM, with a chief complaint of "sent by primary doctor for possible stroke." The triage assessment, completed on March 2, 2007, at 1:05 PM, showed that Patient 105 had a headache, depression,	A 011	ALLEGATION OF COMPLIANCE REGARDING INPATIENTS: The Hospital nevertheless respectfully disagrees that the cited examples support the allegation that the Hospital was not enforcing the Bylaws requirement and not attending to the emergency needs of inpatients for the following reasons: Patient #135: The medical record for this patient documents that the patient came through the ED on May 29, 2007, was admitted to an attending internist, was taken to surgery for an emergency tracheostomy, and then was admitted to the ICU at 1510 that same day. --The consulting pulmonologist was present in the operating room and wrote the initial ICU orders. --The record further reflects that the anesthesiologist and pulmonologist remained in the ICU for a period of time after the patient's admission to assist with stabilizing him. --At 2100, the medical record documents that the patient was becoming restless. --At 2130, the nurses paged the attending physician and the pulmonologist because the patient started bucking the ventilator and the nurses needed orders for medication to calm the patient. --At 2205, the nurses spoke with the surgeon on the case and obtained the necessary medication orders. There was	

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A 011	Continued From page 11 was tired and had a droopy left eye. In the ED, a Computerized Tomography (CT) scan of the head revealed a 7 x 12 mm area of bleeding in the intraparenchymal space (inside of the brain). The ED physician's dictated report dated March 2, 2007, showed that the neurosurgeon on staff was paged, and spoken to at home, but "he does not take call within our hospital, he is out of town and is not available." The ED physician made arrangements to transfer Patient 105 to another facility for a "higher level of care." The ED physician then contacted the house supervisor, "and informed her of the transfer situation...and spoke to the hospital administrator and informed her of the situation, that the patient will be transferred for a higher level of care, as there is no neurosurgical call panel here." Patient 105 was transferred to another facility for neurosurgical services at 11:20 PM, nearly 11 hours after arriving in the ED for treatment. A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two neurosurgeons on active staff. A review of the ED on-call schedule on May 31, 2007, showed that only one neurosurgeon was taking call. b. Patient 118, a 33 year old male, presented to the ED on March 4, 2007, at 2:03 PM, with a chief complaint of an injury to the left leg. An x-ray of the left tibia and fibula showed a "closed comminuted displaced fracture of the left tib-fib" (tibia and fibula). A review of the ED physician's notes showed that "multiple calls were made to the orthopedic physician on call, with no answer." The ED physician transferred Patient 118 to another facility for orthopedic care.	A 011	no documentation indicating that the nurses paged the attending physician or pulmonologist again (which they obviously did not need to do). At this point, there was no need to document if those physicians responded after the conversation with the surgeon and no need to run the chain of command, which would have triggered the HPRR. --The medical record also does not indicate the patient was having an emergency; vital signs were stable and the patient was described only as "restless" when medicated with Ativan 5 minutes later. Hospital staff confirmed that if the nurses required emergency help, they would have called other members of the healthcare team, run the chain of command, and if necessary, also been able to call one of the ED physicians, who are in house 24/7, 365 days/year, to provide assistance. Patient #201: This patient was thoroughly evaluated by a consulting neurologist on 5/24, and the neurologist followed up concerning the status of the patient on 5/25. The neurologist timely dictated his consultation report and notified the patient's attending physician that he would be out of town starting on 5/25. Although an anecdotal report was given to the surveyor by Physician B suggesting that the patient urgently needed a neurologist who refused to come in, Physician B was not involved in this patient's care, and the 2567 does not cite any such problem following chart review. The patient's chart in fact reflects that the consulting neurologist had appropriately notified the	

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A 011	Continued From page 12 c. Patient 119, a 26 year old male, presented to the ED on March 27, 2007, at 10:10 AM, with a chief complaint of multiple seizures after arriving in the recovery room at a local surgery center. Patient 119 continued to have seizures while being transported to the ED by ambulance, and on arrival in the ED. The ED physician diagnosed Patient 119 with Status Epilepticus (uncontrolled seizures). The ED physician's dictated report, dated March 27, 2007, showed that Patient 119 and his family were informed of the treatment plan, "including the potential for transfer to a tertiary care center for neurology, as we have no neurology on-call." The ED physician, "spoke to a staff neurologist, however he was not on call, and agreed with the plan to transfer." The ED physician arranged for Patient 119 to be transferred to another facility, accompanied by a critical care transport team, for neurology care. A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two neurologists on active staff, and two neurologists in provisional status seeking active staff membership. d. Patient 120, a 62 year old male, presented to the ED on April 2, 2007, at 11:58 PM, with a chief complaint of blindness in the right eye. The triage assessment, completed on April 3, 2007, at 12:24 AM, showed that Patient 120 had a sudden onset of loss of vision in his right eye at 10:30 PM, after hitting his head earlier in the day. The ED physician's dictated report, dated April 3, 2007, showed that Patient 120 had signs of a retinal detachment and, "this institution does not have an ophthalmologist on call." Patient 120 was transferred to another facility for a "higher level of	A 011	admitting physician that he would be out of town and identified other neurologists who would be available to see the patient if necessary. The patient was followed by one of the back-up neurologists on 5/26, although the patient was not having a neurological crisis of any kind. Patient #44: This record indicates that the nurse was calling the consulting pulmonologist to report the results of the patient's morning labwork and the fact that the patient was doing well on the ventilator. The consulting pulmonologist responded to the call timely within 30 minutes and asked the nurse to report the results to another pulmonologist who was covering for him/her that day. The second pulmonologist responded to the page timely within 20 minutes. When the on-call pulmonologist was reached, the physician determined that the patient was stable and gave no new orders. The cited examples do not support a finding of noncompliance with the CoPs, or the conclusion that the Hospital was not attending to the emergency needs of inpatients. For these reasons, the Hospital requests that this citation be removed. PLAN OF CORRECTION CONCERNING ED PATIENTS: In addition to actions detailed above with respect primarily to inpatients, the Hospital has taken the following actions with respect to emergency services furnished in the ED:	

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A 011	Continued From page 13 ophthalmological care," at 7:43 AM, nearly eight hours after arrival in the ED for treatment. A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two ophthalmologists on active staff, and one ophthalmologist in provisional status seeking active staff membership. e. Patient 121, a 54 year old female, presented to the ED on April 28, 2007, with a chief complaint of vomiting blood. The ED physician's notes showed that the patient was transferred to another facility for a "higher level of care, no GI (Gastroenterology) service on call." A review of the Medical Staff Roster on May 31, 2007, showed that the facility had six gastroenterologists on active staff. f. Patient 122, a 17 year old male, presented to the ED on April 2, 2007, at 1:53 AM, with a chief complaint of an eye injury. The triage assessment, completed on April 2, 2007, at 2:13 AM, showed that Patient 122 was hit in his right eye earlier in the evening, his eye was reddened and teary, he was unable to see out of his right eye when checking his visual acuity, and he had a large right hyphema (bleeding in the anterior chamber of the eye). The ED physician's notes showed that Patient 122 had a large right hyphema, and would be transferred to another facility due to "no ophthalmology on call at Inland Valley." Patient 122 was transferred to another facility at 3:58 AM, for a "higher level of care." A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two ophthalmologists on active staff, and one	A 011	Regarding current call coverage for the Hospital ED, the Governing Body considered the Medicare Interpretive Guidelines and Survey procedures concerning the Emergency Services Condition of Participation and of the more specific EMTALA rules, and reviewed the anticipated emergency needs of the Hospital's patients. The Governing Body reviewed and confirmed the staffing of the ED with appropriate personnel and with ED physicians qualified to handle most emergencies. The Governing Body revisited the following key factors with respect to the Hospital's staffing of the on-call roster for the ED: --What specialties met the most frequent needs for emergency services and the fact that these specialties should be scheduled to be on call for the ED as close to 24/7, 365 days/year as possible. These specialties are: medicine/family practice, general surgery, orthopedics, obstetrics/gynecology, cardiology, trauma surgery, neurosurgery, pediatrics, and anesthesiology; --What services and facilities the Hospital offered, including the services and facilities the Hospital did not offer (e.g., the fact that the Hospital does not have a psychiatric unit, a NICU, interventional cardiology, or the specialized equipment to perform complex opthalmology procedures such as the surgery to repair retinal detachment);	06/18/07 06/18/07 06/18/07 & 07/03/07

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A 011	Continued From page 14 ophthalmologist in provisional status seeking active staff membership. g. Patient 124, a 17 year old female, presented to the ED on April 13, 2007, at 7:03 PM, with a chief complaint of bloody urine and vomiting. The triage assessment completed on April 13, 2007, at 7:19 PM, showed that Patient 124 had lower abdominal pain, with vomiting every 2 hours for a week. She also complained of weakness and dizziness. The ED physician's notes showed that Patient 124 was in Acute Renal (kidney) Failure, and had Anemia (low blood counts). The ED physician called the pediatrician on call, who was not available to care for Patient 124. Patient 124 was transferred to another facility for care and treatment at 2:11 AM, nearly seven hours after arriving in the ED for treatment. h. Patient 129, a 44 year old male, presented to the ED on April 8, 2007, at 11:50 PM, with a chief complaint of chest pain and shortness of breath. The ED physician's notes showed that the patient had Congestive Heart Failure, Hypertension and Cardiomegaly (enlarged heart). On April 9, 2007, at 4 AM, the physician on call for Internal Medicine was called by the ED physician to admit the patient. At 6 AM, there was no response from the on call physician, and another call was placed. At 7 AM, the on call physician called in to the ED, and agreed to admit the patient. The response time for this on call physician was three hours. The Emergency Medicine (EM) minutes for IVMC were reviewed on May 30, 2007, at 10:45 AM, and again on May 31, 2007, at 12:55 PM. There was no evidence of a discussion regarding the lack of availability of specialists on-call on	A 011	--The types of emergency services that the emergency physicians can provide without the need for a specialty consult or specialty evaluation in the ED because they have the training and experience to provide them, with the assistance of internists/family practitioners, orthopedists, and surgeons who are on call for the ED 24/7, 365 days/year. Such services include, e.g., allergy, dermatology, podiatry, radiation/oncology, hematology/oncology, etc.; -- The number of physicians on staff, including the number on active staff in each specialty who have committed to provide on-call coverage for the ED; --Other demands on these physicians (practice and surgery schedules, participation in medical staff leadership activities, peer review activities, utilization review, vacations, requirements to obtain continuing medical education, etc.); --The frequency with which the Hospital's patients typically require services of certain specialists in the ED; --The provisions the Hospital has made for situations in which a physician in a particular specialty is not on call or the on-call physician is unable to respond. Such provisions include: * The ability to have a general surgeon, trauma surgeon, orthopedic surgeon, obstetrician, pediatrician, neurosurgeon, family practitioner, internist, or hospitalist admit the patient to render appropriate care,	

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A 011	Continued From page 15 weekends and evenings. In September 2006, Page two, section D of the minutes was titled, "Call panel Validation." The minutes stated, "For physicians not on suspension, the ED has calling been to confirm assigned call. The CEO indicated she is working on a plan/process for everyone, and will give information to the ED Medical Director. The CEO indicated the verification of daily assigned call will not be done through the Medical Staff Office." During an interview with the Director of the ED on May 31, 2007, at 11:35 AM, she stated that she was aware that the ED on call schedule did not include all specialties that were offered by the facility. The ED Director stated that she was aware that patients were transferred out of the ED as a result of not having specialty call coverage, and stated that it occurred approximately twice a month to her knowledge, but she only heard about the "particularly messy patients". She stated that the ED physicians complained regularly about the lack of specialty on call coverage, and that they were supposed to be informing the administrator on call every time a patient was transferred to another facility due to no specialist available to care for the patient, then do an HPRR. The ED Director stated that this issue had been reported to administration, and administration answered, "we're discussing it". She stated that this was a "closed administration at the senior level", and that they did not share information with the management team. During an interview with the Director of Performance Improvement (PI) on May 31, 2007, at 12:10 PM, she stated that the issue of not having specialists on call for the ED was discussed "regularly" in the ED committee	A 011	* If a transfer is necessary, having readily available to ED staff a prioritized list of other facilities that are capable of handling various conditions so the ED immediately calls appropriate facilities to seek a transfer, and * Having transfer agreements in place with a number of other facilities to streamline transfer arrangements if those facilities are the appropriate places to send the patient. Hospital Administration and Governing Body members noted that: --CMS recognizes that the Hospital "has the discretion to maintain the on-call list in a manner that best meets the needs of the hospital's patients who are receiving services required under EMTALA" in accordance with the resources available to the hospital, including the availability of on-call physicians. --While CMS recognizes that it is a best practice that the particular services a hospital offers to the public should be available through on-call coverage of the ED, CMS also recognizes that a hospital is not required to have 24/7 coverage in all specialties, and that implementing such coverage in some specialties (e.g., allergy or certain subspecialties with very few physicians) would detract from the availability of the most needed specialists, such as internists/family practitioners, general surgeons, orthopedists, trauma surgeons, neurosurgeons, pediatricians, OB/GYN specialists, and cardiologists.	06/18/07

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A 011	Continued From page 16 meetings, and PI was not involved because "we already knew we had a problem". The Medical Director of the ED (also a member of the Board of Directors) was interviewed on May 31, 2007, at 1:20 PM. He stated that the voluntary call system was "inconvenient" and that often patients were transferred for the lack of an available specialist. He stated that "It's a problem" and that he had empathy for the patients. He stated the primary issue was customer satisfaction. He stated that although many specialties did not have a physician on-call, Urology was the most common specialty to have nobody who would come in to see a patient. He stated the problem with ventilated patients had improved since Physician D joined the pulmonary/intensive care team. However, Physician D was only on-call one week every four weeks. He stated that the ED physicians were "working with what we have to work with." He further stated that no Quality Assurance/Performance Improvement (QAPI) activities were being done to determine the effect the voluntary call system had on patient care, transfers or time spent trying to find a consultant. The Medical Director stated that he spoke at one of the Medical Executive Committee (MEC) meetings, and he told the committee about the difficulty dealing with the voluntary call system; "but until you are in my shoes, looking into the patient's eyes, you cannot know how we (the ED physicians) feel." Findings at RSMC: During a review of ICU medical records on June 1, 2007, the following was noted:	A 011	Administration and ED Physician Leadership reviewed and confirmed there was call coverage for the following specialties, and noted that the citation is mistaken when it says that the Hospital does not have call coverage for neurology and pulmonology, which are provided as follows: --Anesthesiology (on call 24/7, 365 days/year) --Internal Medicine/Family Practice (on call 24/7, 365 days/year) --Pediatrics (on call 24/7, 365 days/year) --OB/Gyn (on call 24/7, 365 days/year) --General Surgery (on call 24/7, 365 days/year) --Orthopedic Surgery (on call 24/7, 365 days/year) --Trauma Surgery (on call 24/7, 365 days/year) --Neurosurgery (on call 24/7 for all but 2-4 days each month) --Cardiology (on call 24/7, nearly 365 days/year) --Neurology (currently on call 24/7 for 7 days a month, with efforts underway to add teleneurology on an expedited basis to provide 24/7 coverage for the rest of each month) --Pulmonology (24/7 for 7 days a month, and because most pulmonary emergencies involve managing patients on a ventilator, a combination of pulmonologists and internists newly credentialed to managed ventilator patients enables additional on call coverage for ventilator patients 24/7 for 20 + days per month, with a goal of coverage nearly every day)	07/02/07

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A 011	Continued From page 17 Patient 44, a 91 year old male, was admitted to the ICU on May 31, 2007, on a ventilator (breathing machine). On June 1, 2007, at 6 AM, the ICU nurse paged Pulmonologist #1, who had done the initial pulmonary consult for ventilator management, to report blood gas results (to show how well the ventilator is assisting the lungs). There was no response, so the ICU nurse repaged Pulmonologist #1 at 6:20 AM. At 6:30 AM, Pulmonologist #1 called back and said he was not on call, but Pulmonologist #2 was. At 6:35 AM, the ICU nurse paged Pulmonologist #2. At 6:45 AM, there was no response from Pulmonologist #2, so the nurse paged again. At 6:45 AM, there was still no response from Pulmonologist #2, so the ICU nurse paged the house supervisor for assistance. At 6:50 AM, Pulmonologist #2 returned his page to the ICU nurse. During an interview with ICU RN 4 on June 1, 2007, at 11:50 AM, the nurse stated that the pulmonology service had been a problem when they were trying to get somebody to manage the patient on a ventilator, but their biggest problem was with neurology. She stated that the neurologists did not have to be on call, and MD 3 told them that he did not have to take call, so if he did not want to come in, he did not have to. ICU RN 4 stated that the ICU nurses made multiple phone calls, and spent hours of their days on the telephone trying to get in touch with doctors. Physician B, a neurologist who provided services at both hospitals, was interviewed on June 1, 2007 at 1:55 PM, by telephone. He stated that there were four neurologists on staff, and that they went to a voluntary call schedule because the call was causing "burn out" among the	A 011	--Vascular Surgery (covered by a specific vascular surgeon when scheduled on Trauma Surgery call panel) Administration and ED Physician Leadership reviewed the specialties not covered by the ED call panel or where there are gaps in coverage, confirmed that it would not be appropriate for some specialties to take call because they do not typically treat emergencies, and therefore identified the appropriate practitioners who provide coverage and who are qualified to assess and provide stabilizing treatment for ED patients with emergencies: --Allergy: ED physicians on site 24/7 for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365 days/year; allergists do not usually handle emergencies --Dentistry: See Oral Surgery; the only dentist on staff practices general dentistry, and any dental emergencies are actually oral surgery issues --Dermatology: ED physicians on site 24/7 for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365 days/year (to the extent a patient may have a dermatological emergency) --Dermatology: ED physicians on site 24/7 for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365 days/year (to the extent a patient may have a dermatological emergency) --Endocrinology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Gastroenterology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year	07/02/07

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A 011	Continued From page 18 physicians. Physician B stated the ED physicians were "pathological dumpers" who didn't want to work-up the patients in the ED. He emphasized that the hospital was not supporting them. He also stated that the administration had arranged call coverage with a new contracted neurologist, but that she was unavailable to come to the facility when she was supposed to be on call, stating that she was not on call, or in Los Angeles. Physician B recommended the survey team review the chart of Patient 201. Reportedly, Patient 201 was an inpatient in the ICU at IVMC. The neurologist involved in the case told the admitting physician that he would be out of town. When a neurologist was urgently needed, the contracted physician was contacted, but was unable or unwilling to come to the facility to provide consultative services for Patient 201. During an interview with ICU RN 5 on June 1, 2007, at 2:43 PM, she stated that she wrote a verbal order for a neurology consult that morning for MD 4 to do. She stated she called MD 4, and was told that MD 5 was on call for neurology, so to call that physician instead. ICU RN 5 called MD 5, and was told that MD 3 was on call for neurology, so call that physician instead. ICU RN 5 stated that if she needed to know who was on call for a specialty, she called the offices and asks if they knew. When she was asked who was on call for neurology that day (June 1, 2007), she answered, "I guess it's MD 3". ICU RN 5 stated that she did not have a call list, but she could call the ED to see who was on call. When she was asked if she was aware that there was nobody on call for neurology for the ED, she stated, "no". In the ICU on June 1, 2007, at 2:52 PM, in the	A 011	--Hematology/Oncology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Infectious Diseases: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Nephrology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Neurology (when there is a gap in coverage): ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year, and Neurosurgeons on call 24/7 for all but 2-4 days/month --Ophthalmology: ED physicians on site 24/7 for 365 days/year; the Hospital does not offer complex ophthalmological surgeries because it does not have the necessary specialized equipment --Oral Surgery: ED physicians on site 24/7 for 365 days/year --Pain Management: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Plastic Surgery: ED physicians on site 24/7 for 365 days/year, and General Surgeons on call 24/7 for 365 days/year --Podiatry: ED physicians on site 24/7 for 365 days/year, Orthopedic Surgeons on call 24/7 for 365 days/year --Psychiatry: Not a service offered by the Hospital because the Hospital does not have a psychiatric unit	

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A 011	Continued From page 19 presence of four ICU nurses and three ICU managers, a general question was asked of them, how much time do you spend making calls to try to find physicians? They all answered, "a lot". Physician G, an Internal Medicine doctor serving both hospitals, was interviewed on June 1, 2007 at 3:25 PM at RSMC. He stated that there had been a "couple of instances" when he had a patient who needed a Neurology consult and was unable to obtain one. He also said that he generally called Physician F when he needed a pulmonology/critical care consult, bypassing the on-call schedule, because he got a better response. He added that "In general, it is not easy to get consultations at this hospital." He also stated that there was poor communication between doctors and administration. During a review of ED medical records on June 1, 2007, the following was noted: a. Patient 31, an 84 year old male, presented to the ED on April 20, 2007, at 5:57 PM, with a chief complaint of a syncopal (dizzy) episode and a fall. The triage assessment, completed on April 20, 2007, at 6:06 PM, showed that Patient 31 had a hematoma (blood pocket under the skin) above the left eye and on the left forehead, and had a headache. The nurse's notes showed that the patients headache continued throughout the ED stay, and he was medicated on five different occasions for the pain. The ED physician dictated report showed that Patient 31 had a Computerized Tomography (CT) scan of his head, that showed a subdural hematoma (bleeding in the brain) on the right side. The ED physician noted that the facility neurosurgeon was	A 011	--Pulmonology: ED physicians on site 24/7 for 365 days/year, Pulmonologists on call 24/7 for 7 days a month, and Internists credentialed to manage patients on ventilators on call 24/7 for most of the remaining 23-24 days per month --Radiation/Oncology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Rheumatology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Urology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Vascular Surgery: Covered 24/7 for several days a month by a specific vascular surgeon when scheduled on the Trauma Surgery call panel Administration and ED Physician Leadership developed a grid to facilitate provision of care by on-call specialists and, when a transfer is necessary, to streamline the arrangements for transfer. Specifically, the grid guides ED staff in calling the appropriate on-call specialist for ED patients, and in calling the hospitals capable of furnishing the specialty care that the patient needs and that the Hospital cannot provide at that time. Administration and ED Physician Leadership reviewed and revised the ED on-call list so that all pertinent information about what physicians are on call appears on one page.	07/03/07 07/03/07

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A 011	Continued From page 20 not on call that day, and "he (Patient 31) will be transferred for a higher level of care, we do not have a neurosurgeon on call at this time". Patient 31 was transferred to another facility at 9 PM, with a blood pressure of 195/66, accompanied by a critical care transport team, for a "higher level of care". A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two neurosurgeons on active staff, and only one neurosurgeon was serving on the ED backup call schedule. A review of the April 2007 Emergency Department On-Call Schedule on May 31, 2007, showed that there was a neurosurgeon scheduled to be on call on April 20, 2007. b. Patient 36, a 60 year old male, presented to the ED on April 4, 2007, at 3:47 AM, with a chief complaint of abdominal pain. The ED physician dictated report showed that the patient had a kidney stone on the right side, and needed to be seen by a urologist. The ED physician contacted a urologist on staff at the facility, who did not come in to see Patient 36. Patient 36 was transferred to another facility at 8:50 AM, for urology care. A review of the Medical Staff Roster on May 31, 2007, showed that the facility had six urologists on active staff. A review of the ED on-call schedule on June 1, 2007, showed the urology service ED call listed as "voluntary". c. Patient 40, a 43 year old male, presented to the	A 011	Administration and the Chair of the PI/RM Committee circulated the grid and revised on-call list to ED staff with a memorandum confirming use of the on-call list and of the grid. Administration clarified that ED staff must contact the appropriate specialist listed on the on-call roster when needed to assess/treat a patient with a possible emergency, rather than calling physicians who are NOT on call. Administration reviewed and clarified that ED staff should arrange for an appropriate transfer when the appropriate on-call specialist is not available, there is a gap in coverage for the ED, the patient requires services the Hospital does not provide, or the patient needs a higher level of care. ED Leadership met with ED staff to discuss the system for using the on-call list and the grid to obtain appropriate emergency care for ED patients in a timely fashion. The CEO and COO are negotiating a contract for teleneurology to be available to the ED 24/7 for all days where there is no neurology coverage, with a projected launch of the system by sometime in fall 2007. Through teleneurology, the ED will have the benefit of neurologists reading tests and ordering appropriate treatment for neurological problems that require prompt treatment (such as administration of TPA). Administration is negotiating to add interventional cardiology as a Hospital service that would be available to both ED patients and hospital inpatients.	07/03/07 07/03/07 07/03/07 07/03/07 In process In process

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A 011	Continued From page 21 ED on April 23, 2007, at 10:28 AM, with a chief complaint of sore throat. The ED physician dictated report showed that Patient 40 had a peritonsillar abscess (an abscess around the tonsils), and was having difficulty swallowing. The ED physician noted that he, "discussed transferring the patient for ENT (Ear, Nose and Throat) services, as we have no ear/nose/throat specialist on call today". Patient 40 was transferred to another facility at 12 PM for a "higher level of care for ENT services". A review of the Medical Staff Roster on May 31, 2007, showed that the facility had three ENT physicians on active staff. A review of the ED on-call schedule on June 1, 2007, showed the ENT service was not listed on the call schedule, either as voluntary or mandatory. d. Patient 203, an elderly female, presented to the ED on May 21, 2007, by ambulance, with a complaint of abdominal pain. The patient had a Computerized Tomography (CT) scan of the abdomen, which was normal. A repeat CT with contrast (used to enhance the image) showed gastritis (inflammation of the stomach). The final diagnoses were Elevated Digoxin Level (a medication used to stimulate a failing heart) and Acute Gastritis. The patient was transferred to another facility for treatment. No documentation was present regarding the reason for transfer. Both of the transfer diagnoses were common medical conditions, usually treated by a cardiologist and a gastroenterologist. Both services were offered at this hospital, however the Gastroenterologists were on a voluntary call schedule for ED back up.	A 011	Administration has initiated the process for adding a NICU, which would be available to both ED patients and hospital inpatients. The Governing Body reviewed and confirmed that the adoption of the voluntary call system did not diminish the availability of emergency services to patients. The Governing Body reviewed the overall rate of transfers out of the ED before and after the implementation of the current call system for the ED. Most significantly, the overall rate of transfers (calculated by dividing the number of transfers by the number of emergency visits for each month) has remained essentially the same, and most of the transfers are done because the patients need services the Hospital does not currently provide (such as psychiatry, interventional cardiology, and NICU services). The Governing Body also reviewed and confirmed that the physicians who elect to participate in taking call for the ED are then obligated to respond to calls from the Hospital: --Once a physician volunteers to participate in call, the on-call physician must respond to the ED at least by telephone within 30 minutes of receiving a call, unless the physician is unable to respond for an appropriate reason (i.e., due to circumstances beyond the physician's control, such as the fact that the on-call physician is in emergency surgery for another patient). --If asked, the on-call physician must come to the ED within 30 minutes and provide care to unassigned patients.	Under constructn 06/18/07 06/18/07

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A 011	Continued From page 22 e. Patient 204, an elderly female, presented to the ED on May 21, 2007. The physician's notes indicated that she was to be admitted to the telemetry unit with a diagnosis of Cerebral Vascular Accident (CVA, stroke). The nurses notes also stated "Admit to telemetry". Patient 204 was instead transferred to another facility. No documentation was present regarding why the admission was changed to a transfer. A CVA was a common neurological condition, usually treated by a neurologist. The hospital provided neurology services, but the neurology service had a voluntary call schedule for ED back up. f. Patient 205, a young man, presented to the ED on May 5, 2007, with a chief complaint of an eye injury. The ED physician noted that there was a laceration to the upper eyelid that would require the services of a plastic surgeon, a specialty service that is offered at this hospital. However, plastic surgery physicians are on a voluntary call schedule. The patient was transferred to another facility for care. g. Patient 206, a female patient, presented to the ED on May 29, 2007, via paramedics, with a chief complaint of inability to speak and right sided weakness. The ED physician's notes indicated the patient had a probable CVA. This was a common neurological condition usually handled by a neurologist, a service offered at this hospital. Patient 206 was transferred to another facility. The ED physician's notes stated, "We do not have neurology on call." Physician E was the prior ED director, and sat on both the Medical Executive Committee (MEC) and the hospital board. He was interviewed on	A 011	--If indicated, during the telephone call, the on-call physician can provide feedback, information, and/or orders to the ED staff to act on while the on-call physician is coming to the ED. For example, when a patient must go to emergency surgery, the Hospital uses the time a surgeon is in transit to the Hospital to gather the OR team and prepare a patient for surgery so there is no delay once the surgeon arrives at the Hospital. Administration provided reminder training to all RN and Respiratory Care Professional staff on the 30 minute response requirement for physicians, how to run the chain of command, and when to complete an HPRR, as described above. The Medical Staff members of the Governing Board drafted and circulated a letter to all Medical Staff members reminding them that they must respond at least by telephone to calls from Hospital staff about their inpatients, and when they are on call for the ED, they must respond by telephone or in person to calls from the ED within 30 minutes, and must come to the ED within 30 minutes when requested. The letter was mailed, faxed, placed in physicians' mailboxes, and posted in all physician areas at both Hospital campuses. Administration reviewed and confirmed several transfer agreements that it has with hospitals to facilitate the transfers of patients from the ED when those facilities are the best facilities available to furnish care the Hospital cannot provide. For example, the Hospital has one transfer agreement specifically with a children's hospital for pediatric transfers.	06/29/07 06/21/07 06/25/07

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A 011	Continued From page 23 May 31, 2007, at 2:30 PM. Physician E stated that he was taking the Chief of Staffs (COS) place in the interview, since she was not available. He stated he had "no perception" of any Quality Assurance/Performance Improvement (QAPI) activities relating to the effects of the institution of voluntary call for specialties on patient care either in the ED or ICU. He stated that the MEC in general seemed to be a "mixed bag" when it comes to the voluntary call. The committee had to balance pro patient care sentiment with pro voluntary call sentiment. He mentioned that there are three staff physicians on the board. He described how the MEC informed the COS that there would be no patient safety issues with voluntary call. The COS, in her reports to the Board, tried to use this information to convince the Board to approve the change in bylaws to allow for voluntary call panels. The COS was not available for comment. Dr. E further stated that at the Board retreat in November, 2006, further discussion about voluntary call occurred, at which time the COS continued to push for the change. During an interview with the ED Unit Secretary (US) on June 1, 2007, at 10:40 AM, the US stated that when she needed to call a specialty physician, she asked the ED physician or the patient's primary care physician (PCP) which specialist they wanted her to call. She then called that specialist and asked them if they would "consider" taking care of the patient. If the specialist declined, she asked the ED physician or the PCP who to call next, and she continued until she found a specialist that was "willing" to take care of the patient. The US stated that she was "usually" able to find somebody to come in. She stated that if they were unable to find a specialist, then the patient got transferred to	A 011	Administration entered into two additional transfer agreements to facilitate transfers from the ED. ED Leadership is responsible for reviewing a random sample for the timely response to page by the ED call panel physician. Please also see description of monitoring for reason and appropriateness of transfers as described earlier in this tag and under A 456 The COO and/or the PI/RM chair are responsible for reporting the analysis of the monitors to the ED Department, the PI/RM Committee, the MEC, and (as indicated) the Governing Body to inform those committees in regularly assessing the appropriateness of on-call coverage for the ED. ALLEGATION OF COMPLIANCE CONCERNING ED PATIENTS The Hospital nevertheless respectfully disagrees that it violated the requirement to approve the medical staff bylaws, rules and regulations with respect to furnishing on-call coverage for the ED. First the bylaws had the appropriate approvals. Second, the citations incorrectly interpret the bylaws and inappropriately expand the rule when they state, "[T]he facility failed to ensure that the medical staff was operating under current bylaws, rules and regulations that were approved by the Governing Body." The CoP on Emergency Services states that hospitals "must meet the emergency needs of patients in accordance with acceptable standards of	06/25/07 07/03/07 & ongoing 07/03/07 & ongoing

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			practice." As noted above, the Interpretive Guidelines further clarify that "acceptable standards of practice" include "maintaining compliance with applicable Federal and State laws, regulations, and guidelines regarding hospital emergency services, as well as any standards or recommendations promoted by or established by nationally recognized professional organizations" such as the AMA, ANA, or ACEP. "Acceptable standards of practice" include the EMTALA rules. Neither the Emergency Services CoP nor EMTALA requires ED call coverage for every service a hospital offers, and the 2567 does not cite any other standards that do. In support of this allegation, for example, Tag A 459 lists specialties that do not have a call panel, including allergy, dermatology, endocrinology, hematology/oncology, infectious disease, nephrology, podiatry, psychiatry, radiation oncology, rheumatology, and vascular surgery. These examples do not support the finding of a violation for the following reasons: --Many of these listed specialties would never be required to manage an emergency because the ED physicians or more general on-call specialists can handle the emergency. For example, ED physicians regularly treat and stabilize allergic reactions and do not call an allergist. --The Hospital does not offer psychiatric services--it has no psychiatric unit or beds; there is one psychiatrist on staff to provide an occasional consult for an inpatient who has psychiatric problems secondary to the medical issues. --The listing of no vascular surgery call panel indicates the surveyors failed to recognize that one of the two vascular surgeons on staff already participates regularly in the trauma call panel providing emergency coverage for the ED.	

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			The Emergency Services CoP further states that there "must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility." This rule likewise does not require 24/7 emergency call coverage for all services offered by the Hospital. CMS recently issued S&C Letter 07-19 on hospital responsibilities for emergency services; that document clarifies that hospitals must "appraise medical emergencies, provide initial treatment and referral when appropriate...." The Hospital meets these requirements as follows: --There is a qualified ED physician on duty at all times in the ED at each hospital campus; --There is a call roster for the ED so that at any given time the ED knows what specialties are covered, and when physicians are on call for the ED, they MUST respond, come to the ED when requested, and provide care to unassigned patients. --The call roster reflects coverage 24/7, nearly 365 days/year by the major specialties needed by ED patients; these include internal medicine/family practice, pediatrics, general surgery, orthopedic surgery, neurosurgery, and cardiology, among others. --The Hospital furnishes 24/7 nursing services and staffs with nurses trained to handle emergencies. Several cases are cited in the 2567 to support the allegation that the Hospital failed to meet the emergency needs of its ED patients. However, instead of showing failure to meet the emergency needs of patients, these cases demonstrate how the Hospital successfully meets the emergency needs of its patients as required under the CoPs. Citing these cases seems to send the message that no patients	

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			should EVER be transferred, when the rules clearly permit appropriate transfers and encourage them when they are necessary to assure patients receive the care they need. Patient #36: The record indicates that the patient received an appropriate medical screening examination, and it was determined that the patient had problems with an indwelling catheter, a procedure that had been performed at the VA hospital. The patient had a long history of treatment at the VA hospital for urological problems. The ED physician consulted with a urologist by phone and was able to evaluate and stabilize the patient. The patient was then transferred to the VA Hospital where the patient had undergone the procedure with an indwelling catheter; the transfer was appropriate for continuity of care. Patient #40: The record indicates that this 40-year-old man had a peritonsillar abscess. There was no ENT physician on call at the time. The ED physician attempted to make arrangements for transfer to a hospital with an ENT on call, which was appropriate and reasonable. Patient #105: On March 2, 2007, this patient was sent to the ED by her primary physician for evaluation of possible stroke and was found to have a bleed. The ED physician was able to talk to one of the neurosurgeons on staff regarding options for the patient, but the neurosurgeon was not on call and was out of town that day. It was nevertheless helpful to the ED physician to consult with the neurosurgeon even though the patient needed to be transferred. The ED physician was able to address any emergent needs the patient had and transferred the patient in a stabilized condition to another hospital. Additionally, the hospital implemented nearly 24/7 call coverage for neurosurgery by March 8, 2007, just after this case occurred. Therefore, the hospital	

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			appropriately transferred this patient, and then improved the call coverage for neurosurgery well before the survey. Patient #118: This patient was evaluated in the ED for a fracture of his left leg. While there was an orthopedic surgeon on call for the ED that day, the patient requested that the ED physician contact the patient's primary care physician about the case. The patient's primary care physician requested that the patient be transferred to the hospital where the primary care physician had privileges and where the patient could continue to be followed by his regular treating orthopedist. After the ED physician stabilized the patient's fracture, he transferred the patient as requested. Patient #119: A review of the medical record of patient #119 indicates the Hospital met the patient's emergency needs as follows: --Although the patient came in at 1010 on March 27, 2007 having seizures and was diagnosed with Status Epilepticus, the Hospital provided medication so that the LAST documented seizure occurred at 1224, and the patient was alert and interacting by 1354. The transfer did not occur for another 6 hours. --The patient was transferred in a stabilized, nonemergent condition at 1623 to a facility with neurologists available to do a complete workup and address ongoing treatment. The patient was no longer having seizures, and the ambulance transporting the patient had a critical care nurse on board merely as a precaution. Patient #120: The 2567 cites patient #120 as an example of a transfer (a) necessitated because there was not an ophthalmologist on call, and (b) done nearly eight hours after the patient's arrival in the ED. An analysis of the record confirmed that neither conclusion is correct.	

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			--The patient would have been transferred even if an ophthalmologist had been available. Because the patient had a possible retinal detachment that could require a complex surgical procedure, and because the Hospital does not have the specialized equipment to do those procedures, the patient was transferred to a tertiary care facility that performs a large number of those procedures. --Additionally, the 2567 states that this patient was transferred at 0743 on April 3, 2007; the medical record documents, however, that the patient left the ED at 0336, about 3 ½ hours after arriving at the ED. Because the patient reported hitting his head, the ED physician had CT scans done of the head and orbits to confirm there were no fractures before arranging a prompt transfer to the tertiary care facility to treat the possible retinal detachment definitively. Patient #121: This patient was evaluated in the ED, where the ED staff found no evidence of GI bleeding after inserting a nasogastric tube and having an abdominal CT done. The patient was offered admission but refused and requested transfer to another hospital. This request was honored, and the patient was transferred. Patient #122: This patient came to the ED needing further examination and treatment by an ophtalmologist. Because there was not an opthalmologist on call for the ED, the patient was appropriate stabilized and transferred to another hospital. Patient #124: This patient was evaluated in the ED and required inpatient admission related to acute renal failure and anemia. However, the patient required care in a pediatric ICU, which the Hospital does not have. Arrangements were made to transfer the patient to a Hospital with a Pediatric ICU that could provide the services required by the patient.	

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			Patient #203: This patient was evaluated for abdominal pain; the first CT scan came back negative, and the second CT scan indicated gastritis. This patient was transferred to another hospital because her primary physician was not on staff at the Hospital. The ED made sure the patient was not in an emergent state, and then transferred her in a stable condition to a hospital where her physician had privileges. Patient # 204: The report incorrectly reports what occurred with this patient. This patient was not transferred. She was admitted to the Hospital. After discussions concerning possible nursing home placement, the patient chose to be discharged home, and the discharge took place the day after admission. Patient #205: This patient was appropriately evaluated in the ED. The patient needed plastic surgery to repair a laceration to his eyelid. However, there were no plastic surgeons on call at the time he presented. The Hospital made arrangements for an appropriate transfer to another hospital that had plastic surgery capability. Patient # 206: An ambulance brought this patient to the ED with possible CVA. The patient was appropriately evaluated. and it was determined that the patient needed to be admitted. Because the patient's primary care physician had privileges at another hospital, the patient requested transfer to that hospital. The patient was transferred after being stabilized. For these reasons, the Hospital submits that the Hospital was and is in compliance with the rules; that this citation should be removed; and that the entire 2567 should be withdrawn.	

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A 011	Continued From page 24 another facility, but "that doesn't happen very often". During an interview with ED Physician 2 on June 1, 2007, at 11:13 AM, he stated that the voluntary call system "made the job more difficult". ED Physician 2 stated that he had been using the Internal Medicine (IM) or Family Practice (FP) physician for advice on what specialist to call. He stated that it took longer to get a specialist now that it was voluntary, and he had to make multiple calls, but he could usually get somebody to come in.	A 011		
A 012	482.12(a)(5) MEDICAL STAFF - ACCOUNTABILITY The governing body must ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the medical staff was accountable to the Governing Body for the provision of on-call physician services for eight of 55 patients at IVMC (Patients 105, 118, 119, 120, 121, 122, 124 and 129), and seven of 68 patients at RSMC (Patients 31, 36, 40, 203, 204, 205 and 206) for the Emergency Department (ED), and three of seven patients at IVMC (Patients 135, 201 and 202), and one of two patients at RSMC (Patient 44) for the Intensive Care Unit (ICU), for specialty medical services provided by the facility, as approved by the Governing Body. Several medical specialties, normally available at the hospitals, failed to provide emergency back-up call or on-call services for hospitalized patients. This resulted in delays in care, unnecessary	A 012	In addition to actions detailed, the Hospital has taken the following actions with respect to emergency services furnished in the ED: Regarding current call coverage for the Hospital ED, the Governing Body considered the Medicare Interpretive Guidelines and Survey procedures concerning the Emergency Services Condition of Participation and of the more specific EMTALA rules, and reviewed the anticipated emergency needs of the Hospital's patients. The Governing Body reviewed and confirmed the staffing of the ED with appropriate personnel and with ED physicians qualified to handle most emergencies. The Governing Body revisited the following key factors with respect to the Hospital's staffing of the on-call roster for the ED:	06/18/07 06/18/07 06/18/07 & 07/03/07

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A 012	Continued From page 25 transfers, and unsafe transfers for ED patients. Care in the ICU was affected due to the lack of 24 hour coverage of ventilator-dependent patients by staff pulmonologists. Findings at IVMC: On May 30, 2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated the practice for the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the Governing Body initially approved the voluntary call system on a trial basis for 90 days, and subsequently extended the trial time on two separate occasions. The current on-call physician coverage for the facility was voluntary. A review of the Medical Staff Bylaws, for IVMC and RSMC, on May 30, 2007, showed that "Each active medical staff member shall actively participate on, and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including but not limited to emergency services and back-up functions....and, Provisional staff members seeking Active staff membership shall serve on the on-call panels appropriate to Active staff members." A review of the Medical Staff Rules and Regulations, for IVMC and RSMC, on May 30, 2007, showed that: Section 1.3.2; "Each practitioner must be available to provide professional care for his/her patients in a timely manner (30 minutes) or	A 012	--What specialties met the most frequent needs for emergency services and the fact that these specialties should be scheduled to be on call for the ED as close to 24/7, 365 days/year as possible. These specialties are: medicine/family practice, general surgery, orthopedics, obstetrics/gynecology, cardiology, trauma surgery, neurosurgery, pediatrics, and anesthesiology; --What services and facilities the Hospital offered, including the services and facilities the Hospital did not offer (e.g., the fact that the Hospital does not have a psychiatric unit, a NICU, interventional cardiology, or the specialized equipment to perform complex opthalmology procedures such as the surgery to repair retinal detachment); --The types of emergency services that the emergency physicians can provide without the need for a specialty consult or specialty evaluation in the ED because they have the training and experience to provide them, with the assistance of internists/family practitioners, orthopedists, and surgeons who are on call for the ED 24/7, 365 days/year. Such services include, e.g., allergy, dermatology, podiatry, radiation/oncology, hematology/oncology, etc.; -- The number of physicians on staff, including the number on active staff in each specialty who have committed to provide on-call coverage for the ED; --Other demands on these physicians (practice and surgery schedules,	

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A 012	Continued From page 26 arrange for an alternate practitioner who has equivalent clinical privileges at the hospital." Section 2.1.1; "A call panel has been established for referring patients who need hospital care to qualified medical staff members. Service on the call panel is not a privilege, but is an obligation of staff membership." Section 2.2.1; "Practitioners on call must respond promptly when requested to see a patient. Practitioners, including specialty consultants, must respond initially by phone or in person within approximately 30 minutes of the time the request to respond is made." Section 2.2.3; "When scheduled on call, each practitioner shall accept the care of all patients who are appropriately referred..." Section 2.2.4; "The on call specialist must also be available for inpatients. If no other specialist in that specialty is willing or able to provide care for a particular inpatient, the on call specialist has the obligation to see that patient to treat, stabilize or appropriately transfer the patient in a timely manner." Section 2.2.7; "A patient will be admitted in the name of the call panel practitioner. The call panel practitioner must be notified about each admission to his service prior to the patient leaving the Emergency Department, and following a discussion with the Emergency Department physician." During a review of ICU medical records on May 30, May 31 and June 1, 2007, the following was noted:	A 012	participation in medical staff leadership activities, peer review activities, utilization review, vacations, requirements to obtain continuing medical education, etc.); --The frequency with which the Hospital's patients typically require services of certain specialists in the ED; --The provisions the Hospital has made for situations in which a physician in a particular specialty is not on call or the on-call physician is unable to respond. Such provisions include: * The ability to have a general surgeon, trauma surgeon, orthopedic surgeon, obstetrician, pediatrician, neurosurgeon, family practitioner, internist, or hospitalist admit the patient to render appropriate care, * If a transfer is necessary, having readily available to ED staff a prioritized list of other facilities that are capable of handling various conditions so the ED immediately calls appropriate facilities to seek a transfer, and * Having transfer agreements in place with a number of other facilities to streamline transfer arrangements if those facilities are the appropriate places to send the patient. Hospital Administration and Governing Body members noted that: --CMS recognizes that the Hospital	06/18/07

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A 012	Continued From page 27 a. Patient 135, a 66 year old male, was admitted to the ICU on May 29, 2007, after an emergency tracheostomy (a tube placed to assist with breathing) was performed in the ED. According to the ICU nurses notes, on May 29, 2007, at 9:30 PM, Patient 135 became agitated and was fighting the ventilator (breathing machine). The ICU nurse paged the patient's primary physician and the pulmonologist for assistance in managing the patient. Neither of these physicians responded to their pages. b. Patient 201, a 76-year-old male was admitted to the ICU on May 24, 2007, with a preliminary diagnosis of Epidural Abscess (collection of pus near the spinal cord). A neurology consultation, dated May 24, 2007, was handwritten in the physician's progress notes. A transcribed, dictated and very detailed neurology consultation was in the medical record, also dated May 24, 2007. The transcribed consultation note was identified as being performed by Physician A. At the end of the dictated consultation, Physician A noted that he would be going out of town, and had notified the admitting physician. c. Patient 202, an elderly gentleman with left-sided weakness and pneumonia was hospitalized in ICU at IVMC during the time of the survey. On May 31, 2007, at 8:15 AM, Patient 202 suffered a deterioration of his respiratory status. The nurses notes contained the timeline of events. Physician H, a neurologist, was at the bedside of Patient 202 when the nurses called Physician F, a Pulmonologist/Intensivist, also Medical Director for Respiratory Services, for assistance with an emergency intubation (placement of a breathing tube into the lungs).	A 012	"has the discretion to maintain the on-call list in a manner that best meets the needs of the hospital's patients who are receiving services required under EMTALA" in accordance with the resources available to the hospital, including the availability of on-call physicians. --While CMS recognizes that it is a best practice that the particular services a hospital offers to the public should be available through on-call coverage of the ED, CMS also recognizes that a hospital is not required to have 24/7 coverage in all specialties, and that implementing such coverage in some specialties (e.g., allergy or certain subspecialties with very few physicians) would detract from the availability of the most needed specialists, such as internists/family practitioners, general surgeons, orthopedists, trauma surgeons, neurosurgeons, pediatricians, OB/GYN specialists, and cardiologists. Administration and ED Physician Leadership reviewed and confirmed there was call coverage for the following specialties, and noted that the citation is mistaken when it says that the Hospital does not have call coverage for neurology and pulmonology, which are provided as follows: --Anesthesiology (on call 24/7, 365 days/year) --Internal Medicine/Family Practice (on call 24/7, 365 days/year) --Pediatrics (on call 24/7, 365 days/year) --OB/Gyn (on call 24/7, 365 days/year) --General Surgery (on call 24/7, 365 days/year)	07/02/07

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A 012	Continued From page 28 According to the nurses notes, Physician F was unavailable to come to the hospital. The nurses then paged Physician I to assist with an emergency intubation. Physician I was also a Pulmonary/Critical Care specialist, although he was not listed on the on-call schedule. The nurses informed Physician I that the patient required emergency intubation, but he was unavailable to come to the hospital at that time. A code blue (patient needing the resuscitation team) was called and Physician J, an ED physician, responded and intubated the patient at approximately 9:05 AM, 50 minutes after the patient was identified to be in severe respiratory distress requiring mechanical ventilation (breathing machine). During an interview with ICU RN 1 on May 30, 2007, at 9:50 AM, she stated that the pulmonologists took call for their own patients during the week, and the on-call pulmonologist covered on the weekends. When she was asked what they did when there was no pulmonologist on call due to the "voluntary" call system, she stated that they called the ED to see if there was somebody on call, and if not, they called all of the pulmonologists on staff until they found one that was available to help them. During an interview with the Director of ICU on May 31, 2007, at 10:20 AM, she stated that she got feedback, from the nurses, for all of the problems that arose in the ICU. According to the Director, the ICU nurses were having a great deal of difficulty getting a pulmonologist to assist with ventilator management up until approximately two months ago. The Director stated with the addition of a new pulmonologist, the problem had improved. She stated she received	A 012	--Orthopedic Surgery (on call 24/7, 365 days/year) --Trauma Surgery (on call 24/7, 365 days/year) --Neurosurgery (on call 24/7 for all but 2-4 days each month) --Cardiology (on call 24/7, nearly 365 days/year) --Neurology (currently on call 24/7 for 7 days a month, with efforts underway to add teleneurology on an expedited basis to provide 24/7 coverage for the rest of each month) --Pulmonology (24/7 for 7 days a month, and because most pulmonary emergencies involve managing patients on a ventilator, a combination of pulmonologists and internists newly credentialed to managed ventilator patients enables additional on call coverage for ventilator patients 24/7 for 20 + days per month, with a goal of coverage nearly every day) --Vascular Surgery (covered by a specific vascular surgeon when scheduled on Trauma Surgery call panel) Administration and ED Physician Leadership reviewed the specialties not covered by the ED call panel or where there are gaps in coverage, confirmed that it would not be appropriate for some specialties to take call because they do not typically treat emergencies, and therefore identified the appropriate practitioners who provide coverage and who are qualified to assess and provide stabilizing treatment for ED patients with emergencies: --Allergy: ED physicians on site 24/7	07/02/07

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A 012	Continued From page 29 approximately two calls per month from the ICU nursing staff related to this problem. She stated that when the ICU staff needed to know who was on call for a specialty, they usually knew by "word of mouth." If not, they called the ED for information. If the ED could not help, they called the offices for that particular specialty and inquired. If the offices didn't know, they went "down the list" and called all of the physicians in that specialty to see if they could get assistance. If they were still unable to get a specialist, they called the ICU Medical Director. The ICU Director stated that when the nursing staff had a delay in getting a response from a physician, they were supposed to write an HPRR (Healthcare Peer Review Report), that was reviewed and investigated by the clinical lead, and forwarded to the Performance Improvement Department. The ICU staff meeting minutes, dated April 19, 2007, were reviewed on May 31, 2007, at 10:50 AM. Under Department Issues, there was a discussion regarding "nurse apathy". The first causative factor of nurse apathy was listed as "MD's do not seem to have accountability, do not answer pages, pass the buck, change phone numbers constantly". During an interview with ICU RN 2 on May 31, 2007, at 11:05 AM, ICU RN 2 stated that she remembered the April 19 staff meeting when the physician accountability was discussed. ICU RN 2 stated that if they need a specialist, they usually "just know who to call". If they did not know, ICU RN 2 stated, "we sometimes have to call all of the doctors on the list for that specialty". She stated that the problem had not improved yet. During an interview with ICU RN 3 on May 31,	A 012	for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365 days/year; allergists do not usually handle emergencies --Dentistry: See Oral Surgery; the only dentist on staff practices general dentistry, and any dental emergencies are actually oral surgery issues --Dermatology: ED physicians on site 24/7 for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365 days/year (to the extent a patient may have a dermatological emergency) --Endocrinology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Gastroenterology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Hematology/Oncology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Infectious Diseases: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Nephrology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Neurology (when there is a gap in coverage): ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year, and Neurosurgeons on call 24/7 for all but 2-4 days/month	

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A 012	Continued From page 30 2007, at 11:15 AM, ICU RN 3 stated that she remembered the April 19 staff meeting where the physician accountability was discussed. ICU RN 3 stated that the problem was worse for the night shift, and on the weekends. She stated that the nurses got tired and frustrated, and "we just want to take care of our patients, and the doctors don't care". ICU RN 3 stated that she had completed HPRR's regarding her inability to reach the physicians. The Director of Respiratory Services was interviewed on May 31, 2007 at 3:25 PM. He stated that in the event a patient on a ventilator needed a change in the machine settings, the pulmonologist on call would be contacted. If there was no pulmonologist on call, or if there was no response to a page, the respiratory therapist would call their Medical Director, Physician F. Physician F is board certified in Pulmonology and in Critical Care. If he was not available, then the "chain of command" was initiated. During a review of ED medical records on May 30 and May 31, 2007, the following was noted: a. Patient 105, a 77 year old female, presented to the ED on March 2, 2007, at 12:36 PM, with a chief complaint of "sent by primary doctor for possible stroke." The triage assessment, completed on March 2, 2007, at 1:05 PM, showed that Patient 105 had a headache, depression, was tired and had a droopy left eye. In the ED, a Computerized Tomography (CT) scan of the head revealed a 7 x 12 mm area of bleeding in the intraparenchymal space (inside of the brain). The ED physician's dictated report dated March 2, 2007, showed that the neurosurgeon on staff was paged, and spoken to at home, but "he does not	A 012	--Ophthalmology: ED physicians on site 24/7 for 365 days/year; the Hospital does not offer complex ophthalmological surgeries because it does not have the necessary specialized equipment --Oral Surgery: ED physicians on site 24/7 for 365 days/year --Pain Management: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Plastic Surgery: ED physicians on site 24/7 for 365 days/year, and General Surgeons on call 24/7 for 365 days/year --Podiatry: ED physicians on site 24/7 for 365 days/year, Orthopedic Surgeons on call 24/7 for 365 days/year --Psychiatry: Not a service offered by the Hospital because the Hospital does not have a psychiatric unit --Pulmonology: ED physicians on site 24/7 for 365 days/year, Pulmonologists on call 24/7 for 7 days a month, and Internists credentialed to manage patients on ventilators on call 24/7 for most of the remaining 23-24 days per month --Radiation/Oncology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Rheumatology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year	

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A 012	Continued From page 31 take call within our hospital, he is out of town and is not available." The ED physician made arrangements to transfer Patient 105 to another facility for a "higher level of care." The ED physician then contacted the house supervisor, "and informed her of the transfer situation...and spoke to the hospital administrator and informed her of the situation, that the patient will be transferred for a higher level of care, as there is no neurosurgical call panel here." Patient 105 was transferred to another facility for neurosurgical services at 11:20 PM, nearly 11 hours after arriving in the ED for treatment. A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two neurosurgeons on active staff. A review of the ED on-call schedule on May 31, 2007, showed that only one neurosurgeon was taking call. b. Patient 118, a 33 year old male, presented to the ED on March 4, 2007, at 2:03 PM, with a chief complaint of an injury to the left leg. An x-ray of the left tibia and fibula showed a "closed comminuted displaced fracture of the left tib-fib" (tibia and fibula). A review of the ED physician's notes showed that "multiple calls were made to the orthopedic physician on call, with no answer." The ED physician transferred Patient 118 to another facility for orthopedic care. c. Patient 119, a 26 year old male, presented to the ED on March 27, 2007, at 10:10 AM, with a chief complaint of multiple seizures after arriving in the recovery room at a local surgery center. Patient 119 continued to have seizures while being transported to the ED by ambulance, and	A 012	--Urology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Vascular Surgery: Covered 24/7 for several days a month by a specific vascular surgeon when scheduled on the Trauma Surgery call panel Administration and ED Physician Leadership developed a grid to facilitate provision of care by on-call specialists and, when a transfer is necessary, to streamline the arrangements for transfer. Specifically, the grid guides ED staff in calling the appropriate on-call specialist for ED patients, and in calling the hospitals capable of furnishing the specialty care that the patient needs and that the Hospital cannot provide at that time. Administration and ED Physician Leadership reviewed and revised the ED on-call list so that all pertinent information about what physicians are on call appears on one page. Administration and the Chair of the PI/RM Committee circulated the grid and revised on-call list to ED staff with a memorandum confirming use of the on-call list and of the grid. Administration clarified that ED staff must contact the appropriate specialist listed on the on-call roster when needed to assess/treat a patient with a possible emergency, rather than calling physicians who are NOT on call.	07/03/07 07/03/07 07/03/07 07/03/07

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A 012	Continued From page 32 on arrival in the ED. The ED physician diagnosed Patient 119 with Status Epilepticus (uncontrolled seizures). The ED physician's dictated report, dated March 27, 2007, showed that Patient 119 and his family were informed of the treatment plan, "including the potential for transfer to a tertiary care center for neurology, as we have no neurology on-call." The ED physician, "spoke to a staff neurologist, however he was not on call, and agreed with the plan to transfer." The ED physician arranged for Patient 119 to be transferred to another facility, accompanied by a critical care transport team, for neurology care. A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two neurologists on active staff, and two neurologists in provisional status seeking active staff membership. d. Patient 120, a 62 year old male, presented to the ED on April 2, 2007, at 11:58 PM, with a chief complaint of blindness in the right eye. The triage assessment, completed on April 3, 2007, at 12:24 AM, showed that Patient 120 had a sudden onset of loss of vision in his right eye at 10:30 PM, after hitting his head earlier in the day. The ED physician's dictated report, dated April 3, 2007, showed that Patient 120 had signs of a retinal detachment and, "this institution does not have an ophthalmologist on call." Patient 120 was transferred to another facility for a "higher level of ophthalmological care," at 7:43 AM, nearly eight hours after arrival in the ED for treatment. A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two ophthalmologists on active staff, and one ophthalmologist in provisional status seeking	A 012	Administration reviewed and clarified that ED staff should arrange for an appropriate transfer when the appropriate on-call specialist is not available, there is a gap in coverage for the ED, the patient requires services the Hospital does not provide, or the patient needs a higher level of care. ED Leadership met with ED staff to discuss the system for using the on-call list and the grid to obtain appropriate emergency care for ED patients in a timely fashion. The CEO and COO are negotiating a contract for teleneurology to be available to the ED 24/7 for all days where there is no neurology coverage, with a projected launch of the system by sometime in fall 2007. Through teleneurology, the ED will have the benefit of neurologists reading tests and ordering appropriate treatment for neurological problems that require prompt treatment (such as administration of TPA). Administration is negotiating to add interventional cardiology as a Hospital service that would be available to both ED patients and hospital inpatients. Administration has initiated the process for adding a NICU, which would be available to both ED patients and hospital inpatients. The Governing Body reviewed and confirmed that the adoption of the voluntary call system did not diminish the availability of emergency services to patients. The Governing Body reviewed the overall rate of transfers out of the ED before and after the implementation of the current call system for the ED. Most significantly,	07/03/07 07/03/07 In process In process Under con-struction 06/18/07

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A 012	Continued From page 33 active staff membership. e. Patient 121, a 54 year old female, presented to the ED on April 28, 2007, with a chief complaint of vomiting blood. The ED physician's notes showed that the patient was transferred to another facility for a "higher level of care, no GI (Gastroenterology) service on call." A review of the Medical Staff Roster on May 31, 2007, showed that the facility had six gastroenterologists on active staff. f. Patient 122, a 17 year old male, presented to the ED on April 2, 2007, at 1:53 AM, with a chief complaint of an eye injury. The triage assessment, completed on April 2, 2007, at 2:13 AM, showed that Patient 122 was hit in his right eye earlier in the evening, his eye was reddened and teary, he was unable to see out of his right eye when checking his visual acuity, and he had a large right hyphema (bleeding in the anterior chamber of the eye). The ED physician's notes showed that Patient 122 had a large right hyphema, and would be transferred to another facility due to "no ophthalmology on call at Inland Valley." Patient 122 was transferred to another facility at 3:58 AM, for a "higher level of care." A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two ophthalmologists on active staff, and one ophthalmologist in provisional status seeking active staff membership. g. Patient 124, a 17 year old female, presented to the ED on April 13, 2007, at 7:03 PM, with a chief complaint of bloody urine and vomiting. The triage assessment completed on April 13, 2007,	A 012	the overall rate of transfers (calculated by dividing the number of transfers by the number of emergency visits for each month) has remained essentially the same, and most of the transfers are done because the patients need services the Hospital does not currently provide (such as psychiatry, interventional cardiology, and NICU services). The Governing Body also reviewed and confirmed that the physicians who elect to participate in taking call for the ED are then obligated to respond to calls from the Hospital: --Once a physician volunteers to participate in call, the on-call physician must respond to the ED at least by telephone within 30 minutes of receiving a call, unless the physician is unable to respond for an appropriate reason (i.e., due to circumstances beyond the physician's control, such as the fact that the on-call physician is in emergency surgery for another patient). --If asked, the on-call physician must come to the ED within 30 minutes and provide care to unassigned patients. --If indicated, during the telephone call, the on-call physician can provide feedback, information, and/or orders to the ED staff to act on while the on-call physician is coming to the ED. For example, when a patient must go to emergency surgery, the Hospital uses the time a surgeon is in transit to the Hospital to gather the OR team and prepare a patient for surgery so	06/18/07

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A 012	Continued From page 34 at 7:19 PM, showed that Patient 124 had lower abdominal pain, with vomiting every 2 hours for a week. She also complained of weakness and dizziness. The ED physician's notes showed that Patient 124 was in Acute Renal (kidney) Failure, and had Anemia (low blood counts). The ED physician called the pediatrician on call, who was not available to care for Patient 124. Patient 124 was transferred to another facility for care and treatment at 2:11 AM, nearly seven hours after arriving in the ED for treatment. h. Patient 129, a 44 year old male, presented to the ED on April 8, 2007, at 11:50 PM, with a chief complaint of chest pain and shortness of breath. The ED physician's notes showed that the patient had Congestive Heart Failure, Hypertension and Cardiomegaly (enlarged heart). On April 9, 2007, at 4 AM, the physician on call for Internal Medicine was called by the ED physician to admit the patient. At 6 AM, there was no response from the on call physician, and another call was placed. At 7 AM, the on call physician called in to the ED, and agreed to admit the patient. The response time for this on call physician was three hours. The Emergency Medicine (EM) minutes were reviewed on May 30, 2007, at 10:45 AM, and again on May 31, 2007 at 12:55 PM. There was no evidence of a discussion regarding the lack of availability of specialists on-call on weekends and evenings. During an interview with the Chief Nursing Executive (CNE) on May 30, 2007, at 11:50 AM, the CNE stated that she received complaints from the nursing staff about the physicians not being available when the nurses called them. The CNE	A 012	there is no delay once the surgeon arrives at the Hospital. Administration provided reminder training to all RN and Respiratory Care Professional staff on the 30 minute response requirement for physicians, how to run the chain of command, and when to complete an HPRR, as described in A 186. The Medical Staff members of the Governing Board drafted and circulated a letter to all Medical Staff members reminding them that they must respond at least by telephone to calls from Hospital staff about their inpatients, and when they are on call for the ED, they must respond by telephone or in person to calls from the ED within 30 minutes, and must come to the ED within 30 minutes when requested. The letter was mailed, faxed, placed in physicians' mailboxes, and posted in all physician areas at both Hospital campuses. Administration reviewed and confirmed several transfer agreements that it has with hospitals to facilitate the transfers of patients from the ED when those facilities are the best facilities available to furnish care the Hospital cannot provide. For example, the Hospital has one transfer agreement specifically with a children's hospital for pediatric transfers. Administration entered into two additional transfer agreements to facilitate transfers from the ED.	06/29/07 06/21/07 06/25/07 06/25/07

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A 012	Continued From page 35 said the complaints were becoming "slightly more" in the ED, and "noticeably more" in the ICU. The CNE stated that there was no particular day of the week, time of day, or specialty that was complained about more. She stated it seemed to be more of an "individual person problem." She declined to give names of the physicians the nursing staff complained about. During an interview with the Director of the ED on May 31, 2007, at 11:35 AM, she stated that she was aware that the ED on call schedule did not include all specialties that were offered by the facility. The ED Director stated that she was aware that patients were transferred out of the ED as a result of not having specialty call coverage, and stated that it occurred approximately twice a month to her knowledge, but she only heard about the "particularly messy patients". She stated that the ED physicians complained regularly about the lack of specialty on call coverage, and that they were supposed to be informing the administrator on call every time a patient was transferred to another facility due to no specialist available to care for the patient, then do an HPRR. The ED Director stated that this issue had been reported to administration, and administration answered, "we're discussing it". She stated that this was a "closed administration at the senior level", and that they did not share information with the management team. During an interview with the Director of Performance Improvement (PI) on May 31, 2007, at 12:10 PM, she stated that the issue of not having specialists on call for the ED was discussed "regularly" in the ED committee meetings, and PI was not involved because "we already knew we had a problem".	A 012	ED Leadership is responsible for reviewing a random sample for the timely response to page by the ED call panel physician. Please also see description of monitoring for reason and appropriateness of transfers as described earlier in this tag and under A 456, and for additional actions to monitor physicians' response to calls under A 186. The COO and/or the PI/RM chair are responsible for reporting the analysis of the monitors to the ED Department, the PI/RM Committee, the MEC, and (as indicated) the Governing Body to inform those committees in regularly assessing the appropriateness of on-call coverage for the ED. ALLEGATION OF COMPLIANCE: The Hospital nevertheless respectfully disagrees that it violated the requirements that the medical staff be accountable to the governing body respect to furnishing on-call coverage for the ED. The citations inappropriately expand the rule when they state that hospital failed to provide appropriate call coverage for approximately 15 patients. That is not the standard established by the Medicare rules. The CoP on Emergency Services states that hospitals "must meet the emergency needs of patients in accordance with acceptable standards of practice." As noted above, the Interpretive Guidelines further clarify that "acceptable standards of practice" include "maintaining compliance with applicable Federal and State laws, regulations, and guidelines regarding hospital emergency services, as	07/03/07 & ongoing 07/03/07 & ongoing

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A 012	Continued From page 36 The Medical Director of the ED (also a member of the Board of Directors) was interviewed on May 31, 2007, at 1:20 PM. He stated that the voluntary call system was "inconvenient" and that often patients were transferred for the lack of an available specialist. He stated that "It's a problem" and that he had empathy for the patients. He stated the primary issue was customer satisfaction. He stated that although many specialties did not have a physician on-call, Urology was the most common specialty to have nobody who would come in to see a patient. He stated the problem with ventilated patients had improved since Physician D joined the pulmonary/intensive care team. However, Physician D was only on-call one week every four weeks. He stated that the ED physicians were "working with what we have to work with." He further stated that no Quality Assurance/Performance Improvement (QAPI) activities were being done to determine the effect the voluntary call system had on patient care, transfers or time spent trying to find a consultant. The Medical Director stated that he spoke at one of the Medical Executive Committee (MEC) meetings, and he told the committee about the difficulty dealing with the voluntary call system; "but until you are in my shoes, looking into the patient's eyes, you cannot know how we (the ED physicians) feel." Physician E was the prior ED director, and sat on both the Medical Executive Committee (MEC) and the hospital board. He was interviewed on May 31, 2007, at 2:30 PM. Physician E stated that he was taking the Chief of Staffs (COS) place in the interview, since she was not available. He stated he had "no perception" of any Quality	A 012	well as any standards or recommendations promoted by or established by nationally recognized professional organizations" such as the AMA, ANA, or ACEP. "Acceptable standards of practice" include the EMTALA rules. Neither the Emergency Services CoP nor EMTALA requires ED call coverage for every service a hospital offers, and the 2567 does not cite any other standards that do. In support of this position, Tag A 459 lists specialties that do not have a call panel, including allergy, dermatology, endocrinology, hematology/oncology, infectious disease, nephrology, podiatry, psychiatry, radiation oncology, rheumatology, and vascular surgery. These examples do not support the finding of a violation for the following reasons: --Many of these listed specialties would never be required to manage an emergency because the ED physicians or more general on-call specialists can handle the emergency. For example, ED physicians regularly treat and stabilize allergic reactions and do not call an allergist.	

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A 012	Continued From page 37 Assurance/Performance Improvement (QAPI) activities relating to the effects of the institution of voluntary call for specialties on patient care either in the ED or ICU. He stated that the MEC in general seemed to be a "mixed bag" when it came to the voluntary call. The committee had to balance pro patient care sentiment with pro voluntary call sentiment. He mentioned that there were three staff physicians on the board. He described how the MEC informed the COS that there would be no patient safety issues with voluntary call. The COS, in her reports to the Board, tried to use this information to convince the Board to approve the change in bylaws to allow for voluntary call panels. The COS was not available for comment. Physician E further stated that at the Board retreat in November, 2006, further discussion about voluntary call occurred, at which time the COS continued to push for the change. Findings at RSMC: During a review of ICU medical records on June 1, 2007, the following was noted: Patient 44, a 91 year old male, was admitted to the ICU on May 31, 2007, on a ventilator (breathing machine). On June 1, 2007, at 6 AM, the ICU nurse paged Pulmonologist #1, who had done the initial pulmonary consult for ventilator management, to report blood gas results (to show how well the ventilator is assisting the lungs). There was no response, so the ICU nurse repaged Pulmonologist #1 at 6:20 AM. At 6:30 AM, Pulmonologist #1 called back and said he was not on call, but Pulmonologist #2 was. At 6:35 AM, the ICU nurse paged Pulmonologist #2. At 6:45 AM, there was no response from	A 012	--The Hospital does not offer psychiatric services--it has no psychiatric unit or beds; there is one psychiatrist on staff to provide an occasional consult for an inpatient who has psychiatric problems secondary to the medical issues. --The listing of no vascular surgery call panel indicates the surveyors failed to recognize that one of the two vascular surgeons on staff already participates regularly in the trauma call panel providing emergency coverage for the ED. The Emergency Services CoP further states that there "must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility." This rule likewise does not require 24/7 emergency call coverage for all services offered by the Hospital. CMS recently issued S&C Letter 07-19 on hospital responsibilities for emergency services; that document clarifies that hospitals must "appraise medical emergencies, provide initial treatment and referral when appropriate...." The Hospital meets these requirements as follows: --There is a qualified ED physician on duty at all times in the ED at each hospital campus; --There is a call roster for the ED so that at any given time the ED knows what specialties are covered, and when physicians are on call for the ED, they MUST respond, come to the ED when requested, and provide care to unassigned	

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A 012	Continued From page 38 Pulmonologist #2, so the nurse paged again. At 6:45 AM, there was still no response from Pulmonologist #2, so the ICU nurse paged the house supervisor for assistance. At 6:50 AM, Pulmonologist #2 returned his page to the ICU nurse. During an interview with ICU RN 4 on June 1, 2007, at 11:50 AM, the nurse stated that the pulmonology service had been a problem when they were trying to get somebody to manage the patient on a ventilator, but their biggest problem was with neurology. She stated that the neurologists did not have to be on call, and MD 3 told them that he did not have to take call, so if he did not want to come in, he did not have to. ICU RN 4 stated that the ICU nurses made multiple phone calls, and spent hours of their days on the telephone trying to get in touch with doctors. Physician B, a neurologist who provided services at both hospitals, was interviewed on June 1, 2007 at 1:55 PM, by telephone. He stated that there were four neurologists on staff, and that they went to a voluntary call schedule because the call was causing "burn out" among the physicians. Physician B stated the ED physicians were "pathological dumpers" who didn't want to work-up the patients in the ED. He emphasized that the hospital was not supporting them. He also stated that the administration had arranged call coverage with a new contracted neurologist, but that she was unavailable to come to the facility when she was supposed to be on call, stating that she was not on call, or in Los Angeles. Physician B recommended the survey team review the chart of Patient 201. Reportedly, Patient 201 was an inpatient in the ICU at IVMC. The neurologist involved in the case told the	A 012	patients. --The call roster reflects coverage 24/7, nearly 365 days/year by the major specialties needed by ED patients; these include internal medicine/family practice, pediatrics, general surgery, orthopedic surgery, neurosurgery, and cardiology, among others. --The Hospital furnishes 24/7 nursing services and staffs with nurses trained to handle emergencies. Several cases are cited in the 2567 to support the allegation that the Hospital failed to meet the emergency needs of its ED patients. However, instead of showing failure to meet the emergency needs of patients, these cases demonstrate how the Hospital successfully meets the emergency needs of its patients as required under the CoPs. Citing these cases seems to send the message that no patients should EVER be transferred, when the rules clearly permit appropriate transfers and encourage them when they are necessary to assure patients receive the care they need. Patient #36: The record indicates that the patient received an appropriate medical screening examination, and it was determined that the patient had problems with an indwelling catheter, a procedure that had been performed at the VA hospital. The patient had a long history of treatment at the VA hospital for urological problems. The ED physician consulted with a urologist by phone and was able to	

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A 012	Continued From page 39 admitting physician that he would be out of town. When a neurologist was urgently needed, the contracted physician was contacted, but was unable or unwilling to come to the facility to provide consultative services for Patient 201. During an interview with ICU RN 5 on June 1, 2007, at 2:43 PM, she stated that she wrote a verbal order for a neurology consult that morning for MD 4 to do. She stated she called MD 4, and was told that MD 5 was on call for neurology, so to call that physician instead. ICU RN 5 called MD 5, and was told that MD 3 was on call for neurology; so call that physician instead. ICU RN 5 stated that if she needed to know who was on call for a specialty, she called the offices and asks if they knew. When she was asked who was on call for neurology that day (June 1, 2007), she answered, "I guess it's MD 3". ICU RN 5 stated that she did not have a call list, but she could call the ED to see who was on call. When she was asked if she was aware that there was nobody on call for neurology for the ED, she stated, "no". In the ICU on June 1, 2007, at 2:52 PM, in the presence of four ICU nurses and three ICU managers, a general question was asked of them, how much time do you spend making calls to try to find physicians? They all answered, "a lot". Physician G, an Internal Medicine doctor serving both hospitals, was interviewed on June 1, 2007 at 3:25 PM at RSMC. He stated that there had been a "couple of instances" when he had a patient who needed a Neurology consult and was unable to obtain one. He also said that he generally called Physician F when he needed a	A 012	evaluate and stabilize the patient. The patient was then transferred to the VA Hospital where the patient had undergone the procedure with an indwelling catheter; the transfer was appropriate for continuity of care. Patient #40: The record indicates that this 40-year-old man had a peritonsillar abscess. There was no ENT physician on call at the time. The ED physician attempted to make arrangements for transfer to a hospital with an ENT on call, which was appropriate and reasonable. Patient #105: On March 2, 2007, this patient was sent to the ED by her primary physician for evaluation of possible stroke and was found to have a bleed. The ED physician was able to talk to one of the neurosurgeons on staff regarding options for the patient, but the neurosurgeon was not on call and was out of town that day. It was nevertheless helpful to the ED physician to consult with the neurosurgeon even though the patient needed to be transferred. The ED physician was able to address any emergent needs the patient had and transferred the patient in a stabilized condition to another hospital. Additionally, the hospital implemented nearly 24/7 call coverage for neurosurgery by March 8, 2007, just after this case occurred. Therefore, the hospital appropriately transferred this patient, and then improved the call coverage for neurosurgery well before the survey. Patient #118: This patient was evaluated in the ED for a fracture of his	

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A 012	Continued From page 40 pulmonology/critical care consult, bypassing the on-call schedule, because he got a better response. He added that "In general, it is not easy to get consultations at this hospital." He also stated that there was poor communication between doctors and administration. During a review of ED medical records on June 1, 2007, the following was noted: a. Patient 31, an 84 year old male, presented to the ED on April 20, 2007, at 5:57 PM, with a chief complaint of a syncopal (dizzy) episode and a fall. The triage assessment, completed on April 20, 2007, at 6:06 PM, showed that Patient 31 had a hematoma (blood pocket under the skin) above the left eye and on the left forehead, and had a headache. The nurse's notes showed that the patients headache continued throughout the ED stay, and he was medicated on five different occasions for the pain. The ED physician dictated report showed that Patient 31 had a Computerized Tomography (CT) scan of his head, that showed a subdural hematoma (bleeding in the brain) on the right side. The ED physician noted that the facility neurosurgeon was not on call that day, and "he (Patient 31) will be transferred for a higher level of care, we do not have a neurosurgeon on call at this time". Patient 31 was transferred to another facility at 9 PM, with a blood pressure of 195/66, accompanied by a critical care transport team, for a "higher level of care". A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two neurosurgeons on active staff, and only one neurosurgeon was serving on the ED backup call schedule.	A 012	left leg. While there was an orthopedic surgeon on call for the ED that day, the patient requested that the ED physician contact the patient's primary care physician about the case. The patient's primary care physician requested that the patient be transferred to the hospital where the primary care physician had privileges and where the patient could continue to be followed by his regular treating orthopedist. After the ED physician stabilized the patient's fracture, he transferred the patient as requested. Patient #119: A review of the medical record of patient #119 indicates the Hospital met the patient's emergency needs as follows: --Although the patient came in at 1010 on March 27, 2007 having seizures and was diagnosed with Status Epilepticus, the Hospital provided medication so that the LAST documented seizure occurred at 1224, and the patient was alert and interacting by 1354. The transfer did not occur for another 6 hours. --The patient was transferred in a stabilized, nonemergent condition at 1623 to a facility with neurologists available to do a complete workup and address ongoing treatment. The patient was no longer having seizures, and the ambulance transporting the patient had a critical care nurse on board merely as a precaution. Patient #120: The 2567 cites patient #120 as an example of a transfer (a) necessitated because there was not an	

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A 012	Continued From page 41 A review of the April 2007 Emergency Department On-Call Schedule on May 31, 2007, showed that there was a neurosurgeon scheduled to be on call on April 20, 2007. b. Patient 36, a 60 year old male, presented to the ED on April 4, 2007, at 3:47 AM, with a chief complaint of abdominal pain. The ED physician dictated report showed that the patient had a kidney stone on the right side, and needed to be seen by a urologist. The ED physician contacted a urologist on staff at the facility, who did not come in to see Patient 36. Patient 36 was transferred to another facility at 8:50 AM, for urology care. A review of the Medical Staff Roster on May 31, 2007, showed that the facility had six urologists on active staff. A review of the ED on-call schedule on June 1, 2007, showed the urology service ED call listed as "voluntary". c. Patient 40, a 43 year old male, presented to the ED on April 23, 2007, at 10:28 AM, with a chief complaint of sore throat. The ED physician dictated report showed that Patient 40 had a peritonsillar abscess (an abscess around the tonsils), and was having difficulty swallowing. The ED physician noted that he, "discussed transferring the patient for ENT (Ear, Nose and Throat) services, as we have no ear/nose/throat specialist on call today". Patient 40 was transferred to another facility at 12 PM for a "higher level of care for ENT services". A review of the Medical Staff Roster on May 31,	A 012	ophthalmologist on call, and (b) done nearly eight hours after the patient's arrival in the ED. An analysis of the record confirmed that neither conclusion is correct. --The patient would have been transferred even if an ophthalmologist had been available. Because the patient had a possible retinal detachment that could require a complex surgical procedure, and because the Hospital does not have the specialized equipment to do those procedures, the patient was transferred to a tertiary care facility that performs a large number of those procedures. --Additionally, the 2567 states that this patient was transferred at 0743 on April 3, 2007; the medical record documents, however, that the patient left the ED at 0336, about 3 ½ hours after arriving at the ED. Because the patient reported hitting his head, the ED physician had CT scans done of the head and orbits to confirm there were no fractures before arranging a prompt transfer to the tertiary care facility to treat the possible retinal detachment definitively. Patient #121: This patient was evaluated in the ED, where the ED staff found no evidence of GI bleeding after inserting a nasogastric tube and having an abdominal CT done. The patient was offered admission but refused and requested transfer to another hospital. This request was honored, and the patient was transferred.	

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A 012	Continued From page 42 2007, showed that the facility had three ENT physicians on active staff. A review of the ED on-call schedule on June 1, 2007, showed the ENT service was not listed on the call schedule, either as voluntary or mandatory. d. Patient 203, an elderly female, presented to the ED on May 21, 2007, by ambulance, with a complaint of abdominal pain. The patient had a Computerized Tomography (CT) scan of the abdomen, which was normal. A repeat CT with contrast (used to enhance the image) showed gastritis (inflammation of the stomach). The final diagnoses were Elevated Digoxin Level (a medication used to stimulate a failing heart) and Acute Gastritis. The patient was transferred to another facility for treatment. No documentation was present regarding the reason for transfer. Both of the transfer diagnoses were common medical conditions, usually treated by a cardiologist and a gastroenterologist. Both services were offered at this hospital, however the Gastroenterologists were on a voluntary call schedule for ED back up. e. Patient 204, an elderly female, presented to the ED on May 21, 2007. The physician's notes indicated that she was to be admitted to the telemetry unit with a diagnosis of Cerebral Vascular Accident (CVA, stroke). The nurses notes also stated "Admit to telemetry". Patient 204 was instead transferred to another facility. No documentation was present regarding why the admission was changed to a transfer. A CVA was a common neurological condition, usually treated by a neurologist. The hospital provided neurology services, but the neurology service had a	A 012	Patient #122: This patient came to the ED needing further examination and treatment by an ophtalmologist. Because there was not an opthalmologist on call for the ED, the patient was appropriate stabilized and transferred to another hospital. Patient #124: This patient was evaluated in the ED and required inpatient admission related to acute renal failure and anemia. However, the patient required care in a pediatric ICU, which the Hospital does not have. Arrangements were made to transfer the patient to a Hospital with a Pediatric ICU that could provide the services required by the patient. Patient #203: This patient was evaluated for abdominal pain; the first CT scan came back negative, and the second CT scan indicated gastritis. This patient was transferred to another hospital because her primary physician was not on staff at the Hospital. The ED made sure the patient was not in an emergent state, and then transferred her in a stable condition to a hospital where her physician had privileges. Patient # 204: The report incorrectly reports what occurred with this patient. This patient was not transferred. She was admitted to the Hospital. After discussions concerning possible nursing home placement, the patient chose to be discharged home, and the discharge took place the day after admission.	

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A 012	Continued From page 43 voluntary call schedule for ED back up. f. Patient 205, a young man, presented to the ED on May 5, 2007, with a chief complaint of an eye injury. The ED physician noted that there was a laceration to the upper eyelid that would require the services of a plastic surgeon, a specialty service that is offered at this hospital. However, plastic surgery physicians are on a voluntary call schedule. The patient was transferred to another facility for care. g. Patient 206, a female patient, presented to the ED on May 29, 2007, via paramedics, with a chief complaint of inability to speak and right sided weakness. The ED physician's notes indicated the patient had a probable CVA. This was a common neurological condition usually handled by a neurologist, a service offered at this hospital. Patient 206 was transferred to another facility. The ED physician's notes stated, "We do not have neurology on call." During an interview with the ED Unit Secretary (US) on June 1, 2007, at 10:40 AM, the US stated that when she needed to call a specialty physician, she asked the ED physician or the patient's primary care physician (PCP) which specialist they wanted her to call. She then called that specialist and asked them if they would "consider" taking care of the patient. If the specialist declined, she asked the ED physician or the PCP who to call next, and she continued until she found a specialist that was "willing" to take care of the patient. The US stated that she was "usually" able to find somebody to come in. She stated that if they were unable to find a specialist, then the patient got transferred to another facility, but "that doesn't happen very	A 012	Patient #205: This patient was appropriately evaluated in the ED. The patient needed plastic surgery to repair a laceration to his eyelid. However, there were no plastic surgeons on call at the time he presented. The Hospital made arrangements for an appropriate transfer to another hospital that had plastic surgery capability. Patient # 206: An ambulance brought this patient to the ED with possible CVA. The patient was appropriately evaluated. and it was determined that the patient needed to be admitted. Because the patient's primary care physician had privileges at another hospital, the patient requested transfer to that hospital. The patient was transferred after being stabilized. For these reasons, the Hospital submits that the Hospital was and is in compliance with the rules; that this citation should be removed; and that the entire 2567 should be withdrawn.	

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A 012	Continued From page 44 often". During an interview with ED Physician 2 on June 1, 2007, at 11:13 AM, he stated that the voluntary call system "made the job more difficult". ED Physician 2 stated that he had been using the Internal Medicine (IM) or Family Practice (FP) physician for advice on what specialist to call. He stated that it took longer to get a specialist now that it was voluntary, and he had to make multiple calls, but he could usually get somebody to come in.	A 012		
A 015	482.12(b) CHIEF EXECUTIVE OFFICER The governing body must appoint a chief executive officer who is responsible for managing the hospital. This STANDARD is not met as evidenced by: Based on interview and record review, the Chief Executive Officer failed to manage the facility to ensure that physician on-call services were provided to patients in accordance with the medical staff bylaws, rules and regulations, for 11 of 62 patients at IVMC (Patient 135, 201, 202, 105, 118, 119, 120, 121, 122, 124 and 129), and eight of 70 patients at RSMC (Patient 44, 31, 36, 40, 203, 204, 205 and 206). Findings at IVMC: On May 30, 2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated the practice for the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the	A 015	This tag quotes provisions from the Medical Staff Bylaws and Rules and Regulations, while mixing up those that apply on the inpatient side and those that apply to ED call coverage. Likewise, the examples cited are a mix of examples of inpatients and ED patients, and physician responsibilities differ depending on whether the patient is admitted or in the ED. The Bylaws and Rules and Regulations state clearly that physicians who admit patients to the hospital are responsible for responding promptly to calls about their patients or arranging for coverage when they are unavailable. With respect to the ED, although physicians have discretion about volunteering to participate on the ED call list, once they agree to take call for the ED, they must respond and come in when requested. Plan of Correction for Inpatients: Administration reviewed and confirmed that the Bylaws and Rules and Regulations had been revised and approved in February 2007.	07/13/07

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A 015	Continued From page 45 Governing Body initially approved the voluntary call system on a trial basis for 90 days, and subsequently extended the trial time on two separate occasions. The current on-call physician coverage for the facility was voluntary. A review of the Medical Staff Bylaws, for IVMC and RSMC, on May 30, 2007, showed that "Each active medical staff member shall actively participate on, and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including but not limited to emergency services and back-up functions....and, Provisional staff members seeking Active staff membership shall serve on the on-call panels appropriate to Active staff members." A review of the Medical Staff Rules and Regulations, for IVMC and RSMC, on May 30, 2007, showed that: Section 1.3.2; "Each practitioner must be available to provide professional care for his/her patients in a timely manner (30 minutes) or arrange for an alternate practitioner who has equivalent clinical privileges at the hospital." Section 2.1.1; "A call panel has been established for referring patients who need hospital care to qualified medical staff members. Service on the call panel is not a privilege, but is an obligation of staff membership." Section 2.2.1; "Practitioners on call must respond promptly when requested to see a patient. Practitioners, including specialty consultants, must respond initially by phone or in person within approximately 30 minutes of the time the request	A 015	Administration reviewed and identified several provisions, such as Rule section 2.1.1, that retained some language about ED coverage being an obligation of all medical staff members. The Governing Body reviewed section 2.1.1 and clarified how such a provision should be interpreted in light of the decision to make participation on the ED call list voluntary. The Governing Body forwarded the interpretation to the Medical Executive Committee (MEC) for review and consideration of revision when the Rules and Regulations are next amended. The Governing Body issued a letter to all Medical Staff members emphasizing the interpretation of Rule section 2.1.1. that participation on the ED call panel may be voluntary, but that any physician serving on the call panel is obligated to respond. The Governing Body reviewed the CMS Conditions of Participation requirements, Interpretive Guidelines, and survey procedures concerning Medical Staff Bylaws. The Hospital Governing Body and MEC leadership reviewed and confirmed that physicians who admit their patients to the Hospital must be available to provide care for their patients in a timely manner or arrange for an alternate practitioner who has equivalent clinical privileges at the Hospital. The Hospital Governing Body and MEC leadership reviewed and confirmed that participation on the call panel for the ED	07/13/07 07/16/07 08/03/07 06/18/07 06/18/07 06/18/07

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A 015	Continued From page 46 to respond is made." Section 2.2.3; "When scheduled on call, each practitioner shall accept the care of all patients who are appropriately referred..." Section 2.2.4; "The on call specialist must also be available for inpatients. If no other specialist in that specialty is willing or able to provide care for a particular inpatient, the on call specialist has the obligation to see that patient to treat, stabilize or appropriately transfer the patient in a timely manner." Section 2.2.7; "A patient will be admitted in the name of the call panel practitioner. The call panel practitioner must be notified about each admission to his service prior to the patient leaving the Emergency Department, and following a discussion with the Emergency Department physician." During a review of ICU medical records on May 30, May 31 and June 1, 2007, the following was noted: a. Patient 135, a 66 year old male, was admitted to the ICU on May 29, 2007, after an emergency tracheostomy (a tube placed to assist with breathing) was performed in the ED. According to the ICU nurses notes, on May 29, 2007, at 9:30 PM, Patient 135 became agitated and was fighting the ventilator (breathing machine). The ICU nurse paged the patient's primary physician and the pulmonologist for assistance in managing the patient. Neither of these physicians responded to their pages. b. Patient 201, a 76-year-old male was admitted	A 015	is not mandatory at this time, but that when a physician agrees to participate on the call panel and is on call for the ED, the physician MUST respond to the Hospital timely when called, MUST come to the Hospital timely to render care when requested, and MUST see all unassigned patients as requested. The Hospital Governing Body and MEC reviewed and confirmed the Medical Staff Bylaws provisions regarding the timeframe for responding to calls from the Hospital regarding the emergency needs of patients (both inpatients and ED patients): --Physicians with admitted patients must respond timely (within 30 minutes) or arrange for another comparable physician to take call and respond timely, AND --Physicians on call for the ED must respond by phone or in person within 30 minutes, and must come to the Hospital within 30 minutes to render care when asked to do so. When the on-call physician has responded first by telephone, he/she can give direction/orders for testing or interventions (as appropriate) while the physician is traveling to the Hospital. The Medical Staff members of the Governing Board drafted and circulated a letter to all Medical Staff members reminding them that they must respond at least by telephone to calls from Hospital staff about their inpatients, and when they are on call for the ED, they must respond by telephone or in person to calls from the	06/18/07 06/21/07

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A 015	Continued From page 47 to the ICU on May 24, 2007, with a preliminary diagnosis of Epidural Abscess (collection of pus near the spinal cord). A neurology consultation, dated May 24, 2007, was handwritten in the physician's progress notes. A transcribed, dictated and very detailed neurology consultation was in the medical record, also dated May 24, 2007. The transcribed consultation note was identified as being performed by Physician A. At the end of the dictated consultation, Physician A noted that he would be going out of town, and had notified the admitting physician. c. Patient 202, an elderly gentleman with left-sided weakness and pneumonia was hospitalized in ICU at IVMC during the time of the survey. On May 31, 2007, at 8:15 AM, Patient 202 suffered a deterioration of his respiratory status. The nurses notes contained the timeline of events. Physician H, a neurologist, was at the bedside of Patient 202 when the nurses called Physician F, a Pulmonologist/Intensivist, also Medical Director for Respiratory Services, for assistance with an emergency intubation (placement of a breathing tube into the lungs). According to the nurses notes, Physician F was unavailable to come to the hospital. The nurses then paged Physician I to assist with an emergency intubation. Physician I was also a Pulmonary/Critical Care specialist, although he was not listed on the on-call schedule. The nurses informed Physician I that the patient required emergency intubation, but he was unavailable to come to the hospital at that time. A code blue (patient needing the resuscitation team) was called and Physician J, an ED physician, responded and intubated the patient at approximately 9:05 AM, 50 minutes after the patient was identified to be in severe respiratory	A 015	ED within 30 minutes, and must come to the ED within 30 minutes when requested. The letter was mailed, faxed, placed in physicians' mailboxes, and posted in all physician areas at both Hospital campuses. The Governing Body approved the recommendations of the Department of Medicine and of the MEC to grant the requests of several internal medicine physicians for additional privileges to manage ventilator patients. As part of this recommendation and approval process, the Department of Medicine, the MEC, and the Governing Body reviewed the categories of physicians allowed to hold ventilator management privileges at multiple hospitals in the surrounding areas. Additionally, these groups recognized that privileges were appropriate for physicians whose scope of practice encompasses this area of patient care management, and that ventilator management is by far the most common emergent need associated with pulmonary care. --These physicians had demonstrated competency and submitted their requests for additional privileges before the survey took place. --The granting of these additional privileges increased the pool of consultants available to provide assistance with ventilator management, to take call in this area and to be available to Hospital Administration and Medical Staff leadership if nursing staff invokes the chain of command to address a patient's sudden change in condition.	06/18/07

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A 015	Continued From page 48 distress requiring mechanical ventilation (breathing machine). During an interview with ICU RN 1 on May 30, 2007, at 9:50 AM, she stated that the pulmonologists took call for their own patients during the week, and the on-call pulmonologist covered on the weekends. When she was asked what they did when there was no pulmonologist on call due to the "voluntary" call system, she stated that they called the ED to see if there was somebody on call, and if not, they called all of the pulmonologists on staff until they found one that was available to help them. During an interview with the Director of ICU on May 31, 2007, at 10:20 AM, she stated that she got feedback, from the nurses, for all of the problems that arose in the ICU. According to the Director, the ICU nurses were having a great deal of difficulty getting a pulmonologist to assist with ventilator management up until approximately two months ago. The Director stated with the addition of a new pulmonologist, the problem had improved. She stated she received approximately two calls per month from the ICU nursing staff related to this problem. She stated that when the ICU staff needed to know who was on call for a specialty, they usually knew by "word of mouth." If not, they called the ED for information. If the ED could not help, they called the offices for that particular specialty and inquired. If the offices didn't know, they went "down the list" and called all of the physicians in that specialty to see if they could get assistance. If they were still unable to get a specialist, they called the ICU Medical Director. The ICU Director stated that when the nursing staff had a delay in getting a response from a physician, they were	A 015	Administration and ED Physician Leadership revised the on-call roster for the ED so that a pulmonologist or internist privileged to manage patients on ventilators was on call almost 24/7 for the next month, with the goal of providing ventilator management coverage 24/7, 365 days a year going forward. Administration reviewed and confirmed the Hospital has an effective process for obtaining timely assistance from physicians for inpatients with emergency needs: --As has long been the standard of practice, attending physicians direct the care of their patients and are responsible for obtaining consults by specialists, as they deem necessary, and for arranging coverage for themselves when they are not available. If an inpatient has an emergency, the nursing staff first calls the attending physician or the physician covering for the attending. --Other physicians already consulting on the patient's treatment team are likewise obligated to respond if called and to provide coverage for themselves. --As a backup in an emergency, there is an ED physician in-house at each hospital, 24/7, 365 days a year. --As further backup, if there is a need for a specialist not already consulting on the case, the nursing staff may contact the appropriate physician on the on-call panel for the ED if one is on the schedule,	07/03/07 06/18/07

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A 015	Continued From page 49 supposed to write an HPRR (Healthcare Peer Review Report), that was reviewed and investigated by the clinical lead, and forwarded to the Performance Improvement Department. The ICU staff meeting minutes, dated April 19, 2007, were reviewed on May 31, 2007, at 10:50 AM. Under Department Issues, there was a discussion regarding "nurse apathy". The first causative factor of nurse apathy was listed as "MD's do not seem to have accountability, do not answer pages, pass the buck, change phone numbers constantly". During an interview with ICU RN 2 on May 31, 2007, at 11:05 AM, ICU RN 2 stated that she remembered the April 19 staff meeting when the physician accountability was discussed. ICU RN 2 stated that if they need a specialist, they usually "just know who to call". If they did not know, ICU RN 2 stated, "we sometimes have to call all of the doctors on the list for that specialty". She stated that the problem had not improved yet. During an interview with ICU RN 3 on May 31, 2007, at 11:15 AM, ICU RN 3 stated that she remembered the April 19 staff meeting where the physician accountability was discussed. ICU RN 3 stated that the problem was worse for the night shift, and on the weekends. She stated that the nurses got tired and frustrated, and "we just want to take care of our patients, and the doctors don't care". ICU RN 3 stated that she had completed HPRR's regarding her inability to reach the physicians. The Director of Respiratory Services was interviewed on May 31, 2007 at 3:25 PM. He stated that in the event a patient on a ventilator	A 015	because as the 2567 notes, section 2.2.4 of the Medical Staff Rules states that assisting with inpatient emergencies is a requirement for any physician while on call for the ED. --Because there may be occasions when there is not on-call coverage for the ED in the desired specialty, there is a need for a specialty consultant to address an emergency, and the attending physician has not found a consultant, the nursing staff can run the chain of command to get medical staff assistance with finding a consultant. --As a final and rare option, the Hospital may arrange to transfer the patient to another facility that can address the patient's problem. Administration reviewed and confirmed the Hospital has an effective process for enforcing these requirements. The chain of command assists the nursing staff in responding to the needs of patients, and the reporting and monitoring system is the tool for enforcing the Bylaws provision as follows: --When a physician does not respond timely to a page and the nurses have to run the chain of command as necessary to meet an urgent patient care need, they are supposed to generate a Healthcare Peer Review Report (HPRR). --The information in the HPRR goes to the physician's Department Chair to address with the physician informally.	06/18/07

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A 015	Continued From page 50 needed a change in the machine settings, the pulmonologist on call would be contacted. If there was no pulmonologist on call, or if there was no response to a page, the respiratory therapist would call their Medical Director, Physician F. Physician F is board certified in Pulmonology and in Critical Care. If he was not available, then the "chain of command" was initiated. During a review of ED medical records on May 30 and May 31, 2007, the following was noted: a. Patient 105, a 77 year old female, presented to the ED on March 2, 2007, at 12:36 PM, with a chief complaint of "sent by primary doctor for possible stroke." The triage assessment, completed on March 2, 2007, at 1:05 PM, showed that Patient 105 had a headache, depression, was tired and had a droopy left eye. In the ED, a Computerized Tomography (CT) scan of the head revealed a 7 x 12 mm area of bleeding in the intraparenchymal space (inside of the brain). The ED physician's dictated report dated March 2, 2007, showed that the neurosurgeon on staff was paged, and spoken to at home, but "he does not take call within our hospital, he is out of town and is not available." The ED physician made arrangements to transfer Patient 105 to another facility for a "higher level of care." The ED physician then contacted the house supervisor, "and informed her of the transfer situation...and spoke to the hospital administrator and informed her of the situation, that the patient will be transferred for a higher level of care, as there is no neurosurgical call panel here." Patient 105 was transferred to another facility for neurosurgical services at 11:20 PM, nearly 11 hours after arriving in the ED for treatment.	A 015	--The information in the HPRR is also kept for tracking purposes and for consideration during the physician's recredentialing process. --If a physician shows a trend of slow response to pages, then the Hospital holds a formal meeting with the physician to discuss the problem and corrective action, and the physician is monitored after that for a period of time to be sure there are no further delays in responding to pages. Department Managers/Directors reviewed with nursing staff members and Respiratory Care Professionals the process for running the chain of command and generating an HPRR when a physician does not respond timely to an emergency. Administration confirmed that training on the chain of command is also included in each annual competency update that all staff members complete. The Risk Management Department is responsible for monitoring HPRRs to determine whether any physician shows a trend of delay in response to calls from the Hospital. Risk Management reports to the PI/RM Committee, which reports as appropriate to the MEC and Governing Body. The Department of Medicine met and discussed methods for making it more efficient for nursing staff to reach the physicians with calls about inpatients.	06/29/07 06/29/07 06/29/07 & ongoing 08/01/07

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A 015	Continued From page 51 A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two neurosurgeons on active staff. A review of the ED on-call schedule on May 31, 2007, showed that only one neurosurgeon was taking call. b. Patient 118, a 33 year old male, presented to the ED on March 4, 2007, at 2:03 PM, with a chief complaint of an injury to the left leg. An x-ray of the left tibia and fibula showed a "closed comminuted displaced fracture of the left tib-fib" (tibia and fibula). A review of the ED physician's notes showed that "multiple calls were made to the orthopedic physician on call, with no answer." The ED physician transferred Patient 118 to another facility for orthopedic care. c. Patient 119, a 26 year old male, presented to the ED on March 27, 2007, at 10:10 AM, with a chief complaint of multiple seizures after arriving in the recovery room at a local surgery center. Patient 119 continued to have seizures while being transported to the ED by ambulance, and on arrival in the ED. The ED physician diagnosed Patient 119 with Status Epilepticus (uncontrolled seizures). The ED physician's dictated report, dated March 27, 2007, showed that Patient 119 and his family were informed of the treatment plan, "including the potential for transfer to a tertiary care center for neurology, as we have no neurology on-call." The ED physician, "spoke to a staff neurologist, however he was not on call, and agreed with the plan to transfer." The ED physician arranged for Patient 119 to be transferred to another facility, accompanied by a critical care transport team, for neurology care.	A 015	The Chair of the Department of Medicine is responsible for notifying all members of the Department about how to make it easier for the Hospital nursing staff to reach them when calling about inpatients under their care. The CNE is responsible for updating the intranet phone list that nurses use to contact physicians so that the list reflects the changes the physicians are making to enable nursing staff to reach them more quickly and easily. The CNE provided reminder education to nursing staff, and particularly to ICU nursing staff, about calling codes promptly what a patient becomes emergent. ALLEGATION OF COMPLIANCE CONCERNING INPATIENTS: The Hospital nevertheless respectfully disagrees that the cited examples support the allegation that the Hospital was not enforcing the Bylaws requirement and not attending to the emergency needs of inpatients for the following reasons: Patient #135: The medical record for this patient documents that the patient came through the ED on May 29, 2007, was admitted to an attending internist, was taken to surgery for an emergency tracheostomy, and then was admitted to the ICU at 1510 that same day.	08/31/07 9/15/07 8/30/07

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A 015	Continued From page 52 A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two neurologists on active staff, and two neurologists in provisional status seeking active staff membership. d. Patient 120, a 62 year old male, presented to the ED on April 2, 2007, at 11:58 PM, with a chief complaint of blindness in the right eye. The triage assessment, completed on April 3, 2007, at 12:24 AM, showed that Patient 120 had a sudden onset of loss of vision in his right eye at 10:30 PM, after hitting his head earlier in the day. The ED physician's dictated report, dated April 3, 2007, showed that Patient 120 had signs of a retinal detachment and, "this institution does not have an ophthalmologist on call." Patient 120 was transferred to another facility for a "higher level of ophthalmological care," at 7:43 AM, nearly eight hours after arrival in the ED for treatment. A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two ophthalmologists on active staff, and one ophthalmologist in provisional status seeking active staff membership. e. Patient 121, a 54 year old female, presented to the ED on April 28, 2007, with a chief complaint of vomiting blood. The ED physician's notes showed that the patient was transferred to another facility for a "higher level of care, no GI (Gastroenterology) service on call." A review of the Medical Staff Roster on May 31, 2007, showed that the facility had six gastroenterologists on active staff. f. Patient 122, a 17 year old male, presented to	A 015	--The consulting pulmonologist was present in the operating room and wrote the initial ICU orders. --The record further reflects that the anesthesiologist and pulmonologist remained in the ICU for a period of time after the patient's admission to assist with stabilizing him. --At 2100, the medical record documents that the patient was becoming restless. --At 2130, the nurses paged the attending physician and the pulmonologist because the patient started bucking the ventilator and the nurses needed orders for medication to calm the patient. --At 2205, the nurses spoke with the surgeon on the case and obtained the necessary medication orders. There was no documentation indicating that the nurses paged the attending physician or pulmonologist again (which they obviously did not need to do). At this point, there was no need to document if those physicians responded after the conversation with the surgeon and no need to run the chain of command, which would have triggered the HPRR. --The medical record also does not indicate the patient was having an emergency; vital signs were stable and the patient was described only as "restless" when medicated with Ativan 5 minutes later. Hospital staff confirmed that if the nurses required emergency help, they would have called other members of the	

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A 015	Continued From page 53 the ED on April 2, 2007, at 1:53 AM, with a chief complaint of an eye injury. The triage assessment, completed on April 2, 2007, at 2:13 AM, showed that Patient 122 was hit in his right eye earlier in the evening, his eye was reddened and teary, he was unable to see out of his right eye when checking his visual acuity, and he had a large right hyphema (bleeding in the anterior chamber of the eye). The ED physician's notes showed that Patient 122 had a large right hyphema, and would be transferred to another facility due to "no ophthalmology on call at Inland Valley." Patient 122 was transferred to another facility at 3:58 AM, for a "higher level of care." A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two ophthalmologists on active staff, and one ophthalmologist in provisional status seeking active staff membership. g. Patient 124, a 17 year old female, presented to the ED on April 13, 2007, at 7:03 PM, with a chief complaint of bloody urine and vomiting. The triage assessment completed on April 13, 2007, at 7:19 PM, showed that Patient 124 had lower abdominal pain, with vomiting every 2 hours for a week. She also complained of weakness and dizziness. The ED physician's notes showed that Patient 124 was in Acute Renal (kidney) Failure, and had Anemia (low blood counts). The ED physician called the pediatrician on call, who was not available to care for Patient 124. Patient 124 was transferred to another facility for care and treatment at 2:11 AM, nearly seven hours after arriving in the ED for treatment. h. Patient 129, a 44 year old male, presented to the ED on April 8, 2007, at 11:50 PM, with a chief	A 015	healthcare team, run the chain of command, and if necessary, also been able to call one of the ED physicians, who are in house 24/7, 365 days/year, to provide assistance. Patient #201: This patient was thoroughly evaluated by a consulting neurologist on 5/24, and the neurologist followed up concerning the status of the patient on 5/25. The neurologist timely dictated his consultation report and notified the patient's attending physician that he would be out of town starting on 5/25. Although an anecdotal report was given to the surveyor by Physician B suggesting that the patient urgently needed a neurologist who refused to come in, Physician B was not involved in this patient's care, and the 2567 does not cite any such problem following chart review. The patient's chart in fact reflects that the consulting neurologist had appropriately notified the admitting physician that he would be out of town and identified other neurologists who would be available to see the patient if necessary. The patient was followed by one of the back-up neurologists on 5/26, although the patient was not having a neurological crisis of any kind. Patient #44: This record indicates that the nurse was calling the consulting pulmonologist to report the results of the patient's morning labwork and the fact that the patient was doing well on the ventilator. The consulting pulmonologist responded to the call timely within 30 minutes and asked the nurse to report the	

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A 015	Continued From page 54 complaint of chest pain and shortness of breath. The ED physician's notes showed that the patient had Congestive Heart Failure, Hypertension and Cardiomegaly (enlarged heart). On April 9, 2007, at 4 AM, the physician on call for Internal Medicine was called by the ED physician to admit the patient. At 6 AM, there was no response from the on call physician, and another call was placed. At 7 AM, the on call physician called in to the ED, and agreed to admit the patient. The response time for this on call physician was three hours. The Emergency Medicine (EM) minutes were reviewed on May 30, 2007, at 10:45 AM, and again on May 31, 2007 at 12:55 PM. There was no evidence of a discussion regarding the lack of availability of specialists on-call on weekends and evenings. During an interview with the Chief Nursing Executive (CNE) on May 30, 2007, at 11:50 AM, the CNE stated that she received complaints from the nursing staff about the physicians not being available when the nurses called them. The CNE said the complaints were becoming "slightly more" in the ED, and "noticeably more" in the ICU. The CNE stated that there was no particular day of the week, time of day, or specialty that was complained about more. She stated it seemed to be more of an "individual person problem." She declined to give names of the physicians the nursing staff complained about. During an interview with the Director of the ED on May 31, 2007, at 11:35 AM, she stated that she was aware that the ED on call schedule did not include all specialties that were offered by the facility. The ED Director stated that she was	A 015	results to another pulmonologist who was covering for him/her that day. The second pulmonologist responded to the page timely within 20 minutes. When the on-call pulmonologist was reached, the physician determined that the patient was stable and gave no new orders. The cited examples do not support a finding of noncompliance with the CoPs, or the conclusion that the Hospital was not attending to the emergency needs of inpatients. For these reasons, the Hospital requests that this citation be removed. PLAN OF CORRECTION CONCERNING ED PATIENTS: Regarding current call coverage for the Hospital ED, the Governing Body considered the Medicare Interpretive Guidelines and Survey procedures concerning the Emergency Services Condition of Participation and of the more specific EMTALA rules, and reviewed the anticipated emergency needs of the Hospital's patients. The Governing Body reviewed and confirmed the staffing of the ED with appropriate personnel and with ED physicians qualified to handle most emergencies. The Governing Body revisited the following key factors with respect to the Hospital's staffing of the on-call roster for the ED:	06/18/07 06/18/07 06/18/07 & 07/03/07

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A 015	Continued From page 55 aware that patients were transferred out of the ED as a result of not having specialty call coverage, and stated that it occurred approximately twice a month to her knowledge, but she only heard about the "particularly messy patients". She stated that the ED physicians complained regularly about the lack of specialty on call coverage, and that they were supposed to be informing the administrator on call every time a patient was transferred to another facility due to no specialist available to care for the patient, then do an HPRR. The ED Director stated that this issue had been reported to administration, and administration answered, "we're discussing it". She stated that this was a "closed administration at the senior level", and that they did not share information with the management team. During an interview with the Director of Performance Improvement (PI) on May 31, 2007, at 12:10 PM, she stated that the issue of not having specialists on call for the ED was discussed "regularly" in the ED committee meetings, and PI was not involved because "we already knew we had a problem". The Medical Director of the ED (also a member of the Board of Directors) was interviewed on May 31, 2007, at 1:20 PM. He stated that the voluntary call system was "inconvenient" and that often patients were transferred for the lack of an available specialist. He stated that "It's a problem" and that he had empathy for the patients. He stated the primary issue was customer satisfaction. He stated that although many specialties did not have a physician on-call, Urology was the most common specialty to have nobody who would come in to see a patient. He stated the problem with ventilated patients had	A 015	--What specialties met the most frequent needs for emergency services and the fact that these specialties should be scheduled to be on call for the ED as close to 24/7, 365 days/year as possible. These specialties are: medicine/family practice, general surgery, orthopedics, obstetrics/gynecology, cardiology, trauma surgery, neurosurgery, pediatrics, and anesthesiology; --What services and facilities the Hospital offered, including the services and facilities the Hospital did not offer (e.g., the fact that the Hospital does not have a psychiatric unit, a NICU, interventional cardiology, or the specialized equipment to perform complex opthalmology procedures such as the surgery to repair retinal detachment); --The types of emergency services that the emergency physicians can provide without the need for a specialty consult or specialty evaluation in the ED because they have the training and experience to provide them, with the assistance of internists/family practitioners, orthopedists, and surgeons who are on call for the ED 24/7, 365 days/year. Such services include, e.g., allergy, dermatology, podiatry, radiation/oncology, hematology/oncology, etc.; -- The number of physicians on staff, including the number on active staff in each specialty who have committed to provide on-call coverage for the ED; --Other demands on these physicians (practice and surgery schedules,	

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A 015	Continued From page 56 improved since Physician D joined the pulmonary/intensive care team. However, Physician D was only on-call one week every four weeks. He stated that the ED physicians were "working with what we have to work with." He further stated that no Quality Assurance/Performance Improvement (QAPI) activities were being done to determine the effect the voluntary call system had on patient care, transfers or time spent trying to find a consultant. The Medical Director stated that he spoke at one of the Medical Executive Committee (MEC) meetings, and he told the committee about the difficulty dealing with the voluntary call system; "but until you are in my shoes, looking into the patient's eyes, you cannot know how we (the ED physicians) feel." Physician E was the prior ED director, and sat on both the Medical Executive Committee (MEC) and the hospital board. He was interviewed on May 31, 2007, at 2:30 PM. Physician E stated that he was taking the Chief of Staffs (COS) place in the interview, since she was not available. He stated he had "no perception" of any Quality Assurance/Performance Improvement (QAPI) activities relating to the effects of the institution of voluntary call for specialties on patient care either in the ED or ICU. He stated that the MEC in general seemed to be a "mixed bag" when it came to the voluntary call. The committee had to balance pro patient care sentiment with pro voluntary call sentiment. He mentioned that there were three staff physicians on the board. He described how the MEC informed the COS that there would be no patient safety issues with voluntary call. The COS, in her reports to the Board, tried to use this information to convince the Board to approve the change in bylaws to	A 015	participation in medical staff leadership activities, peer review activities, utilization review, vacations, requirements to obtain continuing medical education, etc.); --The frequency with which the Hospital's patients typically require services of certain specialists in the ED; --The provisions the Hospital has made for situations in which a physician in a particular specialty is not on call or the on-call physician is unable to respond. Such provisions include: * The ability to have a general surgeon, trauma surgeon, orthopedic surgeon, obstetrician, pediatrician, neurosurgeon, family practitioner, internist, or hospitalist admit the patient to render appropriate care, * If a transfer is necessary, having readily available to ED staff a prioritized list of other facilities that are capable of handling various conditions so the ED immediately calls appropriate facilities to seek a transfer, and * Having transfer agreements in place with a number of other facilities to streamline transfer arrangements if those facilities are the appropriate places to send the patient. Hospital Administration and Governing Body members noted that: --CMS recognizes that the Hospital "has the discretion to maintain the on-call	06/18/07

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A 015	Continued From page 57 allow for voluntary call panels. The COS was not available for comment. Physician E further stated that at the Board retreat in November, 2006, further discussion about voluntary call occurred, at which time the COS continued to push for the change. Findings at RSMC: During a review of ICU medical records on June 1, 2007, the following was noted: Patient 44, a 91 year old male, was admitted to the ICU on May 31, 2007, on a ventilator (breathing machine). On June 1, 2007, at 6 AM, the ICU nurse paged Pulmonologist #1, who had done the initial pulmonary consult for ventilator management, to report blood gas results (to show how well the ventilator is assisting the lungs). There was no response, so the ICU nurse repaged Pulmonologist #1 at 6:20 AM. At 6:30 AM, Pulmonologist #1 called back and said he was not on call, but Pulmonologist #2 was. At 6:35 AM, the ICU nurse paged Pulmonologist #2. At 6:45 AM, there was no response from Pulmonologist #2, so the nurse paged again. At 6:45 AM, there was still no response from Pulmonologist #2, so the ICU nurse paged the house supervisor for assistance. At 6:50 AM, Pulmonologist #2 returned his page to the ICU nurse. During an interview with ICU RN 4 on June 1, 2007, at 11:50 AM, the nurse stated that the pulmonology service had been a problem when they were trying to get somebody to manage the patient on a ventilator, but their biggest problem was with neurology. She stated that the neurologists did not have to be on call, and MD 3	A 015	list in a manner that best meets the needs of the hospital's patients who are receiving services required under EMTALA" in accordance with the resources available to the hospital, including the availability of on-call physicians. --While CMS recognizes that it is a best practice that the particular services a hospital offers to the public should be available through on-call coverage of the ED, CMS also recognizes that a hospital is not required to have 24/7 coverage in all specialties, and that implementing such coverage in some specialties (e.g., allergy or certain subspecialties with very few physicians) would detract from the availability of the most needed specialists, such as internists/family practitioners, general surgeons, orthopedists, trauma surgeons, neurosurgeons, pediatricians, OB/GYN specialists, and cardiologists. Administration and ED Physician Leadership reviewed and confirmed there was call coverage for the following specialties, and noted that the citation is mistaken when it says that the Hospital does not have call coverage for neurology and pulmonology, which are provided as follows: --Anesthesiology (on call 24/7, 365 days/year) --Internal Medicine/Family Practice (on call 24/7, 365 days/year) --Pediatrics (on call 24/7, 365 days/year) --OB/Gyn (on call 24/7, 365 days/year) --General Surgery (on call 24/7, 365 days/year) --Orthopedic Surgery (on call 24/7, 365	07/02/07

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A 015	Continued From page 58 told them that he did not have to take call, so if he did not want to come in, he did not have to. ICU RN 4 stated that the ICU nurses made multiple phone calls, and spent hours of their days on the telephone trying to get in touch with doctors. Physician B, a neurologist who provided services at both hospitals, was interviewed on June 1, 2007 at 1:55 PM, by telephone. He stated that there were four neurologists on staff, and that they went to a voluntary call schedule because the call was causing "burn out" among the physicians. Physician B stated the ED physicians were "pathological dumpers" who didn't want to work-up the patients in the ED. He emphasized that the hospital was not supporting them. He also stated that the administration had arranged call coverage with a new contracted neurologist, but that she was unavailable to come to the facility when she was supposed to be on call, stating that she was not on call, or in Los Angeles. Physician B recommended the survey team review the chart of Patient 201. Reportedly, Patient 201 was an inpatient in the ICU at IVMC. The neurologist involved in the case told the admitting physician that he would be out of town. When a neurologist was urgently needed, the contracted physician was contacted, but was unable or unwilling to come to the facility to provide consultative services for Patient 201. During an interview with ICU RN 5 on June 1, 2007, at 2:43 PM, she stated that she wrote a verbal order for a neurology consult that morning for MD 4 to do. She stated she called MD 4, and was told that MD 5 was on call for neurology, so to call that physician instead. ICU RN 5 called MD 5, and was told that MD 3 was on call for neurology, so call that physician instead. ICU RN	A 015	days/year) --Trauma Surgery (on call 24/7, 365 days/year) --Neurosurgery (on call 24/7 for all but 2-4 days each month) --Cardiology (on call 24/7, nearly 365 days/year) --Neurology (currently on call 24/7 for 7 days a month, with efforts underway to add teleneurology on an expedited basis to provide 24/7 coverage for the rest of each month) --Pulmonology (24/7 for 7 days a month, and because most pulmonary emergencies involve managing patients on a ventilator, a combination of pulmonologists and internists newly credentialed to managed ventilator patients enables additional on call coverage for ventilator patients 24/7 for 20 + days per month, with a goal of coverage nearly every day) --Vascular Surgery (covered by a specific vascular surgeon when scheduled on Trauma Surgery call panel) Administration and ED Physician Leadership reviewed the specialties not covered by the ED call panel or where there are gaps in coverage, confirmed that it would not be appropriate for some specialties to take call because they do not typically treat emergencies, and therefore identified the appropriate practitioners who provide coverage and who are qualified to assess and provide stabilizing treatment for ED patients with emergencies: --Allergy: ED physicians on site 24/7 for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365	07/02/07

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A 015	Continued From page 59 5 stated that if she needed to know who was on call for a specialty, she called the offices and asks if they knew. When she was asked who was on call for neurology that day (June 1, 2007), she answered, "I guess it's MD 3". ICU RN 5 stated that she did not have a call list, but she could call the ED to see who was on call. When she was asked if she was aware that there was nobody on call for neurology for the ED, she stated, "no". In the ICU on June 1, 2007, at 2:52 PM, in the presence of four ICU nurses and three ICU managers, a general question was asked of them, how much time do you spend making calls to try to find physicians? They all answered, "a lot". Physician G, an Internal Medicine doctor serving both hospitals, was interviewed on June 1, 2007 at 3:25 PM at RSMC. He stated that there had been a "couple of instances" when he had a patient who needed a Neurology consult and was unable to obtain one. He also said that he generally called Physician F when he needed a pulmonology/critical care consult, bypassing the on-call schedule, because he got a better response. He added that "In general, it is not easy to get consultations at this hospital." He also stated that there was poor communication between doctors and administration. During a review of ED medical records on June 1, 2007, the following was noted: a. Patient 31, an 84 year old male, presented to the ED on April 20, 2007, at 5:57 PM, with a chief complaint of a syncopal (dizzy) episode and a fall. The triage assessment, completed on April 20,	A 015	days/year; allergists do not usually handle emergencies --Dentistry: See Oral Surgery; the only dentist on staff practices general dentistry, and any dental emergencies are actually oral surgery issues --Dermatology: ED physicians on site 24/7 for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365 days/year (to the extent a patient may have a dermatological emergency) --Dermatology: ED physicians on site 24/7 for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365 days/year (to the extent a patient may have a dermatological emergency) --Endocrinology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Gastroenterology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Hematology/Oncology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Infectious Diseases: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Nephrology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Neurology (when there is a gap in coverage): ED physicians on site 24/7 for 365 days/year, Internists/Family	

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A 015	Continued From page 60 2007, at 6:06 PM, showed that Patient 31 had a hematoma (blood pocket under the skin) above the left eye and on the left forehead, and had a headache. The nurse's notes showed that the patients headache continued throughout the ED stay, and he was medicated on five different occasions for the pain. The ED physician dictated report showed that Patient 31 had a Computerized Tomography (CT) scan of his head, that showed a subdural hematoma (bleeding in the brain) on the right side. The ED physician noted that the facility neurosurgeon was not on call that day, and "he (Patient 31) will be transferred for a higher level of care, we do not have a neurosurgeon on call at this time". Patient 31 was transferred to another facility at 9 PM, with a blood pressure of 195/66, accompanied by a critical care transport team, for a "higher level of care". A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two neurosurgeons on active staff, and only one neurosurgeon was serving on the ED backup call schedule. A review of the April 2007 Emergency Department On-Call Schedule on May 31, 2007, showed that there was a neurosurgeon scheduled to be on call on April 20, 2007. b. Patient 36, a 60 year old male, presented to the ED on April 4, 2007, at 3:47 AM, with a chief complaint of abdominal pain. The ED physician dictated report showed that the patient had a kidney stone on the right side, and needed to be seen by a urologist. The ED physician contacted a urologist on staff at the facility, who did not come in to see Patient 36. Patient 36 was	A 015	Practitioners on call 24/7 for 365 days/year, and Neurosurgeons on call 24/7 for all but 2-4 days/month --Ophthalmology: ED physicians on site 24/7 for 365 days/year; the Hospital does not offer complex ophthalmological surgeries because it does not have the necessary specialized equipment --Oral Surgery: ED physicians on site 24/7 for 365 days/year --Pain Management: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Plastic Surgery: ED physicians on site 24/7 for 365 days/year, and General Surgeons on call 24/7 for 365 days/year --Podiatry: ED physicians on site 24/7 for 365 days/year, Orthopedic Surgeons on call 24/7 for 365 days/year --Psychiatry: Not a service offered by the Hospital because the Hospital does not have a psychiatric unit --Pulmonology: ED physicians on site 24/7 for 365 days/year, Pulmonologists on call 24/7 for 7 days a month, and Internists credentialed to manage patients on ventilators on call 24/7 for most of the remaining 23-24 days per month --Radiation/Oncology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Rheumatology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year	

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A 015	Continued From page 61 transferred to another facility at 8:50 AM, for urology care. A review of the Medical Staff Roster on May 31, 2007, showed that the facility had six urologists on active staff. A review of the ED on-call schedule on June 1, 2007, showed the urology service ED call listed as "voluntary". c. Patient 40, a 43 year old male, presented to the ED on April 23, 2007, at 10:28 AM, with a chief complaint of sore throat. The ED physician dictated report showed that Patient 40 had a peritonsillar abscess (an abscess around the tonsils), and was having difficulty swallowing. The ED physician noted that he, "discussed transferring the patient for ENT (Ear, Nose and Throat) services, as we have no ear/nose/throat specialist on call today". Patient 40 was transferred to another facility at 12 PM for a "higher level of care for ENT services". A review of the Medical Staff Roster on May 31, 2007, showed that the facility had three ENT physicians on active staff. A review of the ED on-call schedule on June 1, 2007, showed the ENT service was not listed on the call schedule, either as voluntary or mandatory. d. Patient 203, an elderly female, presented to the ED on May 21, 2007, by ambulance, with a complaint of abdominal pain. The patient had a Computerized Tomography (CT) scan of the abdomen, which was normal. A repeat CT with contrast (used to enhance the image) showed	A 015	--Urology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Vascular Surgery: Covered 24/7 for several days a month by a specific vascular surgeon when scheduled on the Trauma Surgery call panel Administration and ED Physician Leadership developed a grid to facilitate provision of care by on-call specialists and, when a transfer is necessary, to streamline the arrangements for transfer. Specifically, the grid guides ED staff in calling the appropriate on-call specialist for ED patients, and in calling the hospitals capable of furnishing the specialty care that the patient needs and that the Hospital cannot provide at that time. Administration and ED Physician Leadership reviewed and revised the ED on-call list so that all pertinent information about what physicians are on call appears on one page. Administration and the Chair of the PI/RM Committee circulated the grid and revised on-call list to ED staff with a memorandum confirming use of the on-call list and of the grid. Administration clarified that ED staff must contact the appropriate specialist listed on	07/03/07 07/03/07 07/03/07 07/03/07

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A 015	Continued From page 62 gastritis (inflammation of the stomach). The final diagnoses were Elevated Digoxin Level (a medication used to stimulate a failing heart) and Acute Gastritis. The patient was transferred to another facility for treatment. No documentation was present regarding the reason for transfer. Both of the transfer diagnoses were common medical conditions, usually treated by a cardiologist and a gastroenterologist. Both services were offered at this hospital, however the Gastroenterologists were on a voluntary call schedule for ED back up. e. Patient 204, an elderly female, presented to the ED on May 21, 2007. The physician's notes indicated that she was to be admitted to the telemetry unit with a diagnosis of Cerebral Vascular Accident (CVA, stroke). The nurses notes also stated "Admit to telemetry". Patient 204 was instead transferred to another facility. No documentation was present regarding why the admission was changed to a transfer. A CVA was a common neurological condition, usually treated by a neurologist. The hospital provided neurology services, but the neurology service had a voluntary call schedule for ED back up. f. Patient 205, a young man, presented to the ED on May 5, 2007, with a chief complaint of an eye injury. The ED physician noted that there was a laceration to the upper eyelid that would require the services of a plastic surgeon, a specialty service that is offered at this hospital. However, plastic surgery physicians are on a voluntary call schedule. The patient was transferred to another facility for care. g. Patient 206, a female patient, presented to the ED on May 29, 2007, via paramedics, with a chief	A 015	the on-call roster when needed to assess/treat a patient with a possible emergency, rather than calling physicians who are NOT on call. Administration reviewed and clarified that ED staff should arrange for an appropriate transfer when the appropriate on-call specialist is not available, there is a gap in coverage for the ED, the patient requires services the Hospital does not provide, or the patient needs a higher level of care. ED Leadership met with ED staff to discuss the system for using the on-call list and the grid to obtain appropriate emergency care for ED patients in a timely fashion. The CEO and COO are negotiating a contract for teleneurology to be available to the ED 24/7 for all days where there is no neurology coverage, with a projected launch of the system by sometime in fall 2007. Through teleneurology, the ED will have the benefit of neurologists reading tests and ordering appropriate treatment for neurological problems that require prompt treatment (such as administration of TPA). Administration is negotiating to add interventional cardiology as a Hospital service that would be available to both ED patients and hospital inpatients. Administration has initiated the process for adding a NICU, which would be available to both ED patients and hospital inpatients.	07/03/07 07/03/07 In process In process Under construction

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A 015	Continued From page 63 complaint of inability to speak and right sided weakness. The ED physician's notes indicated the patient had a probable CVA. This was a common neurological condition usually handled by a neurologist, a service offered at this hospital. Patient 206 was transferred to another facility. The ED physician's notes stated, "We do not have neurology on call." During an interview with the ED Unit Secretary (US) on June 1, 2007, at 10:40 AM, the US stated that when she needed to call a specialty physician, she asked the ED physician or the patient's primary care physician (PCP) which specialist they wanted her to call. She then called that specialist and asked them if they would "consider" taking care of the patient. If the specialist declined, she asked the ED physician or the PCP who to call next, and she continued until she found a specialist that was "willing" to take care of the patient. The US stated that she was "usually" able to find somebody to come in. She stated that if they were unable to find a specialist, then the patient got transferred to another facility, but "that doesn't happen very often". During an interview with ED Physician 2 on June 1, 2007, at 11:13 AM, he stated that the voluntary call system "made the job more difficult". ED Physician 2 stated that he had been using the Internal Medicine (IM) or Family Practice (FP) physician for advice on what specialist to call. He stated that it took longer to get a specialist now that it was voluntary, and he had to make multiple calls, but he could usually get somebody to come in.	A 015	The Governing Body reviewed and confirmed that the adoption of the voluntary call system did not diminish the availability of emergency services to patients. The Governing Body reviewed the overall rate of transfers out of the ED before and after the implementation of the current call system for the ED. Most significantly, the overall rate of transfers (calculated by dividing the number of transfers by the number of emergency visits for each month) has remained essentially the same, and most of the transfers are done because the patients need services the Hospital does not currently provide (such as psychiatry, interventional cardiology, and NICU services). The Governing Body also reviewed and confirmed that the physicians who elect to participate in taking call for the ED are then obligated to respond to calls from the Hospital: --Once a physician volunteers to participate in call, the on-call physician must respond to the ED at least by telephone within 30 minutes of receiving a call, unless the physician is unable to respond for an appropriate reason (i.e., due to circumstances beyond the physician's control, such as the fact that the on-call physician is in emergency surgery for another patient). --If asked, the on-call physician must come to the ED within 30 minutes and	06/18/07 06/18/07
A 141	482.21 QAPI	A 141	provide care to unassigned patients.	

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			--If indicated, during the telephone call, the on-call physician can provide feedback, information, and/or orders to the ED staff to act on while the on-call physician is coming to the ED. For example, when a patient must go to emergency surgery, the Hospital uses the time a surgeon is in transit to the Hospital to gather the OR team and prepare a patient for surgery so there is no delay once the surgeon arrives at the Hospital. Administration provided reminder training to all RN and Respiratory Care Professional staff on the 30 minute response requirement for physicians, how to run the chain of command, and when to complete an HPRR, as described in A 186. The Medical Staff members of the Governing Board drafted and circulated a letter to all Medical Staff members reminding them that they must respond at least by telephone to calls from Hospital staff about their inpatients, and when they are on call for the ED, they must respond by telephone or in person to calls from the ED within 30 minutes, and must come to the ED within 30 minutes when requested. The letter was mailed, faxed, placed in physicians' mailboxes, and posted in all physician areas at both Hospital campuses. Administration reviewed and confirmed several transfer agreements that it has with hospitals to facilitate the transfers of patients from the ED when those facilities are the best facilities available to furnish care the Hospital cannot provide.	06/29/07 06/21/07 06/25/07

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			For example, the Hospital has one transfer agreement specifically with a children's hospital for pediatric transfers. Administration entered into two additional transfer agreements to facilitate transfers from the ED.	06/25/07
			ED Leadership is responsible for reviewing a random sample for the timely response to page by the ED call panel physician. Please also see description of monitoring for reason and appropriateness of transfers as described earlier in this tag and under A 456, and for additional actions to monitor physicians' response to calls under A 186.	07/03/07 & ongoing
			The COO and/or the PI/RM chair are responsible for reporting the analysis of the monitors to the ED Department, the PI/RM Committee, the MEC, and (as indicated) the Governing Body to inform those committees in regularly assessing the appropriateness of on-call coverage for the ED.	07/03/07 & ongoing
			ALLEGATION OF COMPLIANCE REGARDING ED PATIENTS: The Hospital nevertheless respectfully disagrees that it violated the acceptable standards of practice with respect to furnishing on-call coverage for the ED. The citations inappropriately expand the rule when they state The CEO failed to manage the facility ensure that physician on-call services were provided to 11 patients in accordance with the Bylaws, Rules and Regulations.	

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			But that is an incorrect reading of the Bylaws, Rules and Regulations and not the standard established by the Medicare rules. The CoP on Emergency Services states that hospitals "must meet the emergency needs of patients in accordance with acceptable standards of practice." As noted above, the Interpretive Guidelines further clarify that "acceptable standards of practice" include "maintaining compliance with applicable Federal and State laws, regulations, and guidelines regarding hospital emergency services, as well as any standards or recommendations promoted by or established by nationally recognized professional organizations" such as the AMA, ANA, or ACEP. "Acceptable standards of practice" include the EMTALA rules. Neither the Emergency Services CoP nor EMTALA requires ED call coverage for every service a hospital offers, and the 2567 does not cite any other standards that do. In support of the citation, Tag A 459 lists specialties that do not have a call panel, including allergy, dermatology, endocrinology, hematology/oncology, infectious disease, nephrology, podiatry, psychiatry, radiation oncology, rheumatology, and vascular surgery. These examples do not support the finding of a violation for the following reasons: --Many of these listed specialties would	

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SOUTHWEST HEALTHCARE SYSTEM	25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562

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			never be required to manage an emergency because the ED physicians or more general on-call specialists can handle the emergency. For example, ED physicians regularly treat and stabilize allergic reactions and do not call an allergist. --The Hospital does not offer psychiatric services--it has no psychiatric unit or beds; there is one psychiatrist on staff to provide an occasional consult for an inpatient who has psychiatric problems secondary to the medical issues. --The listing of no vascular surgery call panel indicates the surveyors failed to recognize that one of the two vascular surgeons on staff already participates regularly in the trauma call panel providing emergency coverage for the ED. The Emergency Services CoP further states that there "must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility." This rule likewise does not require 24/7 emergency call coverage for all services offered by the Hospital. CMS recently issued S&C Letter 07-19 on hospital responsibilities for emergency services; the document clarifies that hospitals must "appraise medical emergencies, provide initial treatment and referral when appropriate...." The Hospital meets these requirements as follows: --There is a qualified ED physician on	

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			duty at all times in the ED at each hospital campus; --There is a call roster for the ED so that at any given time the ED knows what specialties are covered, and when physicians are on call for the ED, they MUST respond, come to the ED when requested, and provide care to unassigned patients. --The call roster reflects coverage 24/7, nearly 365 days/year by the major specialties needed by ED patients; these include internal medicine/family practice, pediatrics, general surgery, orthopedic surgery, neurosurgery, and cardiology, among others. --The Hospital furnishes 24/7 nursing services and staffs with nurses trained to handle emergencies. Several cases are cited in the 2567 to support the allegation that the Hospital failed to meet the emergency needs of its ED patients. However, instead of showing failure to meet the emergency needs of patients, these cases demonstrate how the Hospital successfully meets the emergency needs of its patients as required under the CoPs. Citing these cases seems to send the message that no patients should EVER be transferred, when the rules clearly permit appropriate transfers and encourage them when they are necessary to assure patients receive the care they need.	

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			Patient #36: The record indicates that the patient received an appropriate medical screening examination, and it was determined that the patient had problems with an indwelling catheter, a procedure that had been performed at the VA hospital. The patient had a long history of treatment at the VA hospital for urological problems. The ED physician consulted with a urologist by phone and was able to evaluate and stabilize the patient. The patient was then transferred to the VA Hospital where the patient had undergone the procedure with an indwelling catheter; the transfer was appropriate for continuity of care. Patient #40: The record indicates that this 40-year-old man had a peritonsillar abscess. There was no ENT physician on call at the time. The ED physician attempted to make arrangements for transfer to a hospital with an ENT on call, which was appropriate and reasonable. Patient #105: On March 2, 2007, this patient was sent to the ED by her primary physician for evaluation of possible stroke and was found to have a bleed. The ED physician was able to talk to one of the neurosurgeons on staff regarding options for the patient, but the neurosurgeon was not on call and was out of town that day. It was nevertheless helpful to the ED physician to consult with the neurosurgeon even though the patient needed to be transferred. The ED physician was able to address any emergent needs the patient had and transferred the patient in a stabilized condition to another hospital.	

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			Additionally, the hospital implemented nearly 24/7 call coverage for neurosurgery by March 8, 2007, just after this case occurred. Therefore, the hospital appropriately transferred this patient, and then improved the call coverage for neurosurgery well before the survey. Patient #118: This patient was evaluated in the ED for a fracture of his left leg. While there was an orthopedic surgeon on call for the ED that day, the patient requested that the ED physician contact the patient's primary care physician about the case. The patient's primary care physician requested that the patient be transferred to the hospital where the primary care physician had privileges and where the patient could continue to be followed by his regular treating orthopedist. After the ED physician stabilized the patient's fracture, he transferred the patient as requested. Patient #119: A review of the medical record of patient #119 indicates the Hospital met the patient's emergency needs as follows: --Although the patient came in at 1010 on March 27, 2007 having seizures and was diagnosed with Status Epilepticus, the Hospital provided medication so that the LAST documented seizure occurred at 1224, and the patient was alert and interacting by 1354. The transfer did not occur for another 6 hours. --The patient was transferred in a stabilized, nonemergent condition at 1623	

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			to a facility with neurologists available to do a complete workup and address ongoing treatment. The patient was no longer having seizures, and the ambulance transporting the patient had a critical care nurse on board merely as a precaution. Patient #120: The 2567 cites patient #120 as an example of a transfer (a) necessitated because there was not an ophthalmologist on call, and (b) done nearly eight hours after the patient's arrival in the ED. An analysis of the record confirmed that neither conclusion is correct. --The patient would have been transferred even if an ophthalmologist had been available. Because the patient had a possible retinal detachment that could require a complex surgical procedure, and because the Hospital does not have the specialized equipment to do those procedures, the patient was transferred to a tertiary care facility that performs a large number of those procedures. --Additionally, the 2567 states that this patient was transferred at 0743 on April 3, 2007; the medical record documents, however, that the patient left the ED at 0336, about 3 ½ hours after arriving at the ED. Because the patient reported hitting his head, the ED physician had CT scans done of the head and orbits to confirm there were no fractures before arranging a prompt transfer to the tertiary care facility to treat the possible retinal detachment definitively.	

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			Patient #121: This patient was evaluated in the ED, where the ED staff found no evidence of GI bleeding after inserting a nasogastric tube and having an abdominal CT done. The patient was offered admission but refused and requested transfer to another hospital. This request was honored, and the patient was transferred. Patient #122: This patient came to the ED needing further examination and treatment by an ophtalmologist. Because there was not an opthalmologist on call for the ED, the patient was appropriate stabilized and transferred to another hospital. Patient #124: This patient was evaluated in the ED and required inpatient admission related to acute renal failure and anemia. However, the patient required care in a pediatric ICU, which the Hospital does not have. Arrangements were made to transfer the patient to a Hospital with a Pediatric ICU that could provide the services required by the patient. Patient #203: This patient was evaluated for abdominal pain; the first CT scan came back negative, and the second CT scan indicated gastritis. This patient was transferred to another hospital because her primary physician was not on staff at the Hospital. The ED made sure the patient was not in an emergent state, and then transferred her in a stable condition to a hospital where her physician had privileges.	

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			Patient # 204: The report incorrectly reports what occurred with this patient. This patient was not transferred. She was admitted to the Hospital. After discussions concerning possible nursing home placement, the patient chose to be discharged home, and the discharge took place the day after admission. Patient #205: This patient was appropriately evaluated in the ED. The patient needed plastic surgery to repair a laceration to his eyelid. However, there were no plastic surgeons on call at the time he presented. The Hospital made arrangements for an appropriate transfer to another hospital that had plastic surgery capability. Patient # 206: An ambulance brought this patient to the ED with possible CVA. The patient was appropriately evaluated. and it was determined that the patient needed to be admitted. Because the patient's primary care physician had privileges at another hospital, the patient requested transfer to that hospital. The patient was transferred after being stabilized. For these reasons, the Hospital submits that the Hospital was and is in compliance with the rules; that this citation should be removed; and that the entire 2567 should be withdrawn.	

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A 141	Continued From page 64 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the Quality Assessment and Performance Improvement (QAPI) program was effective and was focused on indicators related to improving health outcomes of patients requiring the services of a specialist due to emergent or critical needs, by failing to: 1. Measure, analyze and track quality indicators to determine the effect a change from mandatory call to voluntary call for some specialties may have on hospital services. (A0145) 2. Collect and utilize data to monitor the effectiveness and safety of instituting a voluntary call panel for some specialties. (A0148) 3. Specify the frequency and detail of data to be collected to monitor the trial of voluntary call.	A 141	Please see actions taken under A 145, A148, A 150, A167, and A169.	

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A 141	Continued From page 65 (A0150) 4. Ensure that the hospital-wide QAPI efforts addressed priorities for improved quality of care, all improvement actions were evaluated and adequate resources were allocated for QAPI activities. (A0167) 5. Ensure that the QAPI program monitored the safety of patients during the trial of voluntary call. (A0169) The cumulative effect of this systemic problem resulted in the failure of the facility to ensure that safe and quality medical care was provided to patients.	A 141		
A 145	482.21(a)(2) QAPI QUALITY INDICATORS The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to measure and analyze quality indicators and other aspects of performance that assess the impact on patient care and safety, when changing from a mandatory emergency back-up call system to a voluntary one. Indicators that might be affected by the change in the call system were not monitored after the change was put into affect, including average patient time in the Emergency Department (ED), frequency of patient transfers due to lack of available specialty services, delays in patient care, unexpected or untoward outcomes due to lack of available	A 145	The Governing Body reviewed the CMS Interpretive Guidelines and survey procedures regarding the requirements for ongoing QAPI activities and the responsibility of the Medical Staff with respect to ongoing and continuing assessment of medical care provided in the ED. The Hospital's Governing Body and Medical Executive Committee (MEC) reviewed and confirmed that Medical Staff departments, including the ED Department, regularly review medical care furnished to ED patients. --ED PI activity is completed regularly on specific cases. --Data is trended and monitored regarding the number of ED patients seen	06/18/07 06/26/07

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A 145	Continued From page 66 specialty services, and time spent by ED and Intensive Care Unit (ICU) staff trying to arrange consultations. Findings: On May 30, 2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated the practice for the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the Governing Body initially approved the voluntary call system on a trial basis for 90 days, and subsequently extended the trial time on two separate occasions. The current on-call physician coverage for the facility was voluntary. Review of the Medical Staff Bylaws (revised 5/22/06) on May 30, 2007, at 1:45 PM, showed that: a. Section 10.5.3; "A supervisory (departmental) committee shall conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department." b. Section 10.8.5; The duties of department chairs include; "Generally monitor the quality and appropriateness of patient care and professional performance provided by members with clinical privileges in the department ...and oversee the	A 145	and the number of transfers occurring, among other things. --Data is tracked at the ED level, and information is reported up through the ED Department to the MEC, and then to the Governing Body as indicated. --Cases of concern may also be referred to the PI/RM Committee for peer review of unresolved issues/concerns after review by the physician's peers/ department. The Hospital's Governing Body and MEC reviewed and confirmed that the QAPI system was monitoring the completeness of transfer documentation, as noted in the citation. The Hospital Governing Body and MEC leadership reviewed and confirmed that participation on the call panel for the ED is not mandatory at this time, but that when a physician agrees to participate on the call panel and is on call for the ED, the physician MUST respond to the Hospital timely when called, MUST come to the Hospital timely to render care when requested, and MUST see all unassigned patients as requested. Administration analyzed transfers for the previous 3 months with a focus on several subspecialties that have little to no coverage, and determined that the majority of transfers were for services the Hospital does not offer (e.g., interventional cardiology, psychiatry, neonatal intensive care (NICU) services), and confirmed that only a very small percentage of transfers	06/26/07 06/18/07 06/01/07

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A 145	Continued From page 67 effective conduct of patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee (MEC)," and also, "enforce Medical Staff Bylaws, Rules and Regulations and policies within the department ..." and, "provide for continuous assessment and improvement of the quality of care and services provided." The Performance Improvement (PI) Committee shall "establish systems to identify potential problems in patient care and general areas of potential risk in clinical aspects of patient care and safety." The minutes of the Governing Body (Board of Governors) were reviewed on May 31, 2007, at 10:10 AM. The minutes from August 2006 contained an entry indicating approval of the voluntary call panel for a trial period of 90 days. The minutes of November 2006 extended the trial period for an additional 90 days. No rationale was given for the continuation of the trial. No data was presented or reviewed regarding the effects that initiation of the voluntary call panel had on hospital departments, staff, or patients. The minutes from January 2007 extended the trial for an additional 6 months, for a total trial period of one year. Again, no supporting data was presented or reviewed. The minutes of the Performance Improvement Committee were reviewed on May 31, 2007, at 11:15 AM. Reviewed minutes spanned from November 2, 2006 to April 5, 2007 (seven months), and included quarterly minutes of the PI Operational Committee. There was no documentation that the trial of voluntary call was ever discussed. There was no evidence of data collection to monitor related patient care indicators in the ED, the ICU or elsewhere in the	A 145	occurred because the ED lacked specialist coverage at the time. The Hospital's Governing Body reviewed and confirmed that: --The ED sees approximately 5,000 patients a month; --The ED transfers a very small percentage of those patients because the Hospital maintains coverage for multiple specialist categories that address most emergent needs (e.g., 24/7, 365 days/year coverage in Internal Medicine/Family Practice, Pediatrics, OB/Gyn, General Surgery, Trauma Surgery, Orthopedic Surgery, and Anesthesiology, and 24/7, nearly 365 days/year coverage for Cardiology & Neurosurgery); --The majority of transfers from the ED are because the patient needs a service the Hospital does not offer, such as interventional cardiology, psychiatry, or neonatal intensive care (NICU) services. --The rate of transfers when physician participation in ED call coverage was mandatory was essentially the same as the rate of transfers under the current system where physicians may elect not to participate on the ED call panel (although as noted above, when a physician elects to take call for the ED, he/she MUST respond to the ED and care for unassigned patients as requested); --The specialties for which there is call coverage have not decreased in the last year, but in fact have increased with the addition of neurosurgery coverage.	06/18/07

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A 145	Continued From page 68 facility. The PI Director was interviewed on May 31, 2007, at 12:10 PM. She stated that no indicators for monitoring the effects of the trial of voluntary call on patient care were being followed. Physician E was interviewed on May 31, 2007, at 2:30 PM. He was the prior ED director, and sat on both the MEC and the Governing Board. Physician E stated he had "no perception" of any QAPI activities relating to the effects, on patient care, of the institution of voluntary call for specialties in the ED or the ICU. The facility Performance Improvement Plan was reviewed on May 30, 2007. The plan included the following: a. Objectives for provision of care which included: 1. A mechanism to assure that all patients received the same level of care; and 2. A culture where care was delivered in a safe environment, and quality care was measured, monitored and continuously improved. b. The responsibilities of the Governing Board included a duty to assure patient care was safely delivered within the guidelines established by the Medical Staff. c. The Medical Executive Committee of the Medical Staff was accountable to the Governing Board to ensure care was delivered in accordance with the Medical Staff Bylaws, Rules and Regulations. d. Measuring and monitoring performance included ensuring that processes, functions or	A 145	The "voluntary call" system has been workable because the medical staff has been able to provide 24/7 coverage for almost 365 days/year in the major areas identified above and in A 459; --Administration and Medical Staff leadership are in the process of negotiating further improvements to the call panel to include teleneurology coverage for the ED; a NICU is currently under construction, and interventional cardiology is scheduled to begin construction in 2008. Hospital Administration enhanced the ongoing monitoring of a random sample of transfers to evaluate: --The appropriateness of and reasons for transfers, with attention to transfers because the Hospital does not offer a particular service and because the ED lacks specialist coverage, and --Overall transfer rates. The PI/RM Committee is responsible for analyzing the monitoring results, for taking actions as appropriate, and for reporting information as indicated monthly to the MEC and, as appropriate, to the Governing Body, which meets 10 times during the year. The PI/RM Committee reviewed data on transfers and the reasons for transfer and drew the same conclusions noted above by Administration and the Governing Body. cont. next page	06/29/07 06/29/07 & ongoing 07/09/07

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A 145	Continued From page 69 services were designed/redesigned well, and met the needs of the individuals served. The ED Quality Assurance/Performance Improvement (QAPI) was reviewed on May 30, 2007. The ED was monitoring compliance with EMTALA transfer regulations, on a quarterly basis, in the following areas: a. The patient's condition was documented; b. The accepting facility was documented; c. The accepting physician was documented; d. Appropriate paperwork was sent with the patient; e. The method of transportation was documented; f. Vital signs were done within 15 minutes of transfer; g. The physician defined the reason for transfer; and h. The consent was signed and witnessed. There was no monitoring regarding the reason for transfer, availability of on-call physician services, appropriateness of transfers or outcomes related to transfers. The Medical Staff and Governing Board had no QAPI data to assess the quality of care provided by the on-call physician services in the ED, or to determine if changes in policies were appropriate, necessary and would meet the needs of the individuals served. During an interview with the Director of Performance Improvement (PI) on May 31, 2007, at 12:10 PM, she stated that the issue of not having specialists on call for the ED was discussed "regularly" in the ED committee meetings, and PI was not involved because "we already knew we had a problem".	A 145	ALLEGATION OF COMPLIANCE: The Hospital nevertheless respectfully disagrees that the citation supports a violation of this rule. Medical and administrative leadership regularly evaluate emergency coverage and anticipated emergency needs on an ongoing basis—as the surveyors saw, this ongoing evaluation is a regular topic of discussion at leadership meetings. The 2567 itself details one of the QAPI monitors used by the Hospital to evaluate transfers. Other monitoring also tracks the number of transfers. The Hospital has determined that it continues to see approximately 5,000 patients a month in the ED; that it transferred a small percentage of its ED patients when there was mandatory call; that it continues to transfer essentially the same small percentage of patients under the current system where physicians elect whether to participate on the call panel for the ED; and that the vast number of these transfers are for services the Hospital does not currently offer, such as psychiatry, interventional cardiology, and NICU services. This consistency in the data indicates that the shift to a system where physicians elect whether to be on the ED call roster has not changed the Hospital's call capability or increased the need to transfer patients. A majority of those transfers are necessary not because the Hospital does not have emergency coverage for a given specialty, but because the Hospital does not offer the service or procedure the	
A 148	482.21(b)(2)(i) QAPI QUALITY OF CARE	A 148		

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	050701	A. BUILDING _____ B. WING _____	C 06/01/2007

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

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			patient needs. As a result of this analysis, the Hospital is taking steps to add identified specialties such as interventional cardiology and a NICU. For these reasons, the Hospital submits that the Hospital was and is in compliance with the rules; and that this citation should be removed.	

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A 148	Continued From page 70 The hospital must use the data collected to monitor the effectiveness and safety of service and quality of care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to collect and use data to monitor the effectiveness and safety of services and quality of care. After changing from a mandatory to a voluntary call system, no data was collected to determine what effect the change had on patient care. The trial of voluntary call was extended twice, for a total of one year, without the collection of data or analysis to assess how such a major change was affecting patient care. Findings: Review of the Medical Staff Bylaws (revised 5/22/06) on May 30, 2007, at 1:45 PM, showed that: a. Section 10.5.3; "A supervisory (departmental) committee shall conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department." b. Section 10.8.5; The duties of department chairs include; "Generally monitor the quality and appropriateness of patient care and professional performance provided by members with clinical privileges in the department ...and oversee the	A 148	In addition to the other actions under A186 and A 459, the Governing Body reviewed the CMS Interpretive Guidelines and survey procedures regarding the requirements for ongoing QAPI activities and the responsibility of the Medical Staff with respect to ongoing and continuing assessment of medical care provided in the ED. The Hospital's Governing Body and Medical Executive Committee (MEC) reviewed and confirmed that Medical Staff departments, including the ED Department, regularly review medical care furnished to ED patients. --ED PI activity is completed regularly on specific cases. --Data is trended and monitored regarding the number of ED patients seen and the number of transfers occurring, among other things. --Data is tracked at the ED level, and information is reported up through the ED Department to the MEC, and then to the Governing Body as indicated. --Cases of concern may also be referred to the PI/RM Committee for peer review of unresolved issues/concerns after review by the physician's peers/ department. The Hospital's Governing Body and MEC reviewed and confirmed that the QAPI system was monitoring the completeness of transfer documentation, as noted in the citation.	06/18/07 06/26/07 06/26/07

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A 148	Continued From page 71 effective conduct of patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee (MEC)," and also, "enforce Medical Staff Bylaws, Rules and Regulations and policies within the department ..." and, "provide for continuous assessment and improvement of the quality of care and services provided." The Performance Improvement (PI) Committee shall "establish systems to identify potential problems in patient care and general areas of potential risk in clinical aspects of patient care and safety." The minutes of the Governing Body (Board of Governors) were reviewed on May 31, 2007, at 10:10 AM. The minutes from August 2006 contained an entry indicating approval of the voluntary call panel for a trial period of 90 days. The minutes of November 2006 extended the trial period for an additional 90 days. No rationale was given for the continuation of the trial. No data was presented or reviewed regarding the effects that initiation of the voluntary call panel had on hospital departments, staff, or patients. The minutes from January 2007 extended the trial for an additional 6 months, for a total trial period of one year. Again, no supporting data was presented or reviewed. The minutes of the Performance Improvement Committee were reviewed on May 31, 2007, at 11:15 AM. Reviewed minutes spanned from November 2, 2006 to April 5, 2007 (seven months), and included quarterly minutes of the PI Operational Committee. There was no documentation that the trial of voluntary call was ever discussed. There was no evidence of data collection to monitor related patient care indicators in the ED, the ICU or elsewhere in the	A 148	The Hospital Governing Body and MEC leadership reviewed and confirmed that participation on the call panel for the ED is not mandatory at this time, but that when a physician agrees to participate on the call panel and is on call for the ED, the physician MUST respond to the Hospital timely when called, MUST come to the Hospital timely to render care when requested, and MUST see all unassigned patients as requested. Administration analyzed transfers for the previous 3 months with a focus on several subspecialties that have little to no coverage, and determined that the majority of transfers were for services the Hospital does not offer (e.g., interventional cardiology, psychiatry, neonatal intensive care (NICU) services), and confirmed that only a very small percentage of transfers occurred because the ED lacked specialist coverage at the time. The Hospital's Governing Body reviewed and confirmed that: --The ED sees approximately 5,000 patients a month; --The ED transfers a very small percentage of those patients because the Hospital maintains 24/7, 365 days/year coverage for multiple specialist categories that address most emergent needs (e.g., Internal Medicine/Family Practice, Pediatrics, OB/Gyn, General Surgery, Orthopedic Surgery, Anesthesiology, and Trauma Surgery), and nearly 24/7, 365 days/year coverage for Cardiology and	06/18/07 06/01/07 06/18/07

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A 148	Continued From page 72 facility. The PI Director was interviewed on May 31, 2007, at 12:10 PM. She stated that no indicators for monitoring the effects of the trial of voluntary call on patient care were being followed. Physician E was interviewed on May 31, 2007, at 2:30 PM. He was the prior ED director, and sat on both the MEC and the Governing Board. Physician E stated he had "no perception" of any QAPI activities relating to the effects, on patient care, of the institution of voluntary call for specialties in the ED or the ICU. The facility Performance Improvement Plan was reviewed on May 30, 2007. The plan included the following: a. Objectives for provision of care which included: 1. A mechanism to assure that all patients received the same level of care; and 2. A culture where care was delivered in a safe environment, and quality care was measured, monitored and continuously improved. b. The responsibilities of the Governing Board included a duty to assure patient care was safely delivered within the guidelines established by the Medical Staff. c. The Medical Executive Committee of the Medical Staff was accountable to the Governing Board to ensure care was delivered in accordance with the Medical Staff Bylaws, Rules and Regulations. d. Measuring and monitoring performance included ensuring that processes, functions or	A 148	Neurosurgery (except 2-4 days/month); --The majority of transfers from the ED are because the patient needs a service the Hospital does not offer, such as interventional cardiology, psychiatry, or neonatal intensive care (NICU) services. --The rate of transfers when physician participation in ED call coverage was mandatory was essentially the same as the rate of transfers under the current system where physicians may elect not to participate on the ED call panel (although as noted above, when a physician elects to take call for the ED, he/she MUST respond to the ED and care for unassigned patients as requested); --The specialties for which there is call coverage have not decreased in the last year, but in fact have increased with the addition of neurosurgery coverage. The "voluntary call" system has been workable because the medical staff has been able to provide 24/7 coverage for almost 365 days/year in the major areas identified above and in A 459; --Administration and Medical Staff leadership are in the process of negotiating further improvements to the call panel to include teleneurology coverage for the ED; a NICU is currently under construction, and interventional cardiology is scheduled to begin construction in 2008. Hospital Administration enhanced the ongoing monitoring of a random sample of transfers to evaluate:	06/29/07

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A 148	Continued From page 73 services were designed/redesigned well, and met the needs of the individuals served. The ED Quality Assurance/Performance Improvement (QAPI) was reviewed on May 30, 2007. The ED was monitoring compliance with EMTALA transfer regulations, on a quarterly basis, in the following areas: a. The patient's condition was documented; b. The accepting facility was documented; c. The accepting physician was documented; d. Appropriate paperwork was sent with the patient; e. The method of transportation was documented; f. Vital signs were done within 15 minutes of transfer; g. The physician defined the reason for transfer; and h. The consent was signed and witnessed. There was no monitoring regarding the reason for transfer, availability of on-call physician services, appropriateness of transfers or outcomes related to transfers. The Medical Staff and Governing Board had no QAPI data to assess the quality of care provided by the on-call physician services in the ED, or to determine if changes in policies were appropriate, necessary and would meet the needs of the individuals served. During an interview with the Director of Performance Improvement (PI) on May 31, 2007, at 12:10 PM, she stated that the issue of not having specialists on call for the ED was discussed "regularly" in the ED committee meetings, and PI was not involved because "we already knew we had a problem".	A 148	--The appropriateness of and reasons for transfers, with attention to transfers because the Hospital does not offer a particular service and because the ED lacks specialist coverage, and --Overall transfer rates. The PI/RM Committee is responsible for analyzing the monitoring results, for taking actions as appropriate, and for reporting information as indicated monthly to the MEC and, as appropriate, to the Governing Body, which meets 10 times during the year. The PI/RM Committee reviewed data on transfers and the reasons for transfer and drew the same conclusions noted above by Administration and the Governing Body. ALLEGATION OF COMPLIANCE: The Hospital nevertheless respectfully disagrees that the citation supports a violation of this rule. Medical and administrative leadership regularly evaluate emergency coverage and anticipated emergency needs on an ongoing basis—as the surveyors saw, this ongoing evaluation is a regular topic of discussion at leadership meetings. The 2567 itself details one of the QAPI monitors used by the Hospital to evaluate transfers. Other monitoring also tracks the number of transfers.	06/29/07 & ongoing 07/09/07
A 150	482.21(b)(3) QAPI PROGRAM DATA	A 150		

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			The Hospital has determined that it continues to see approximately 5,000 patients a month in the ED; that it transferred a small percentage of its ED patients when there was mandatory call; that it continues to transfer essentially the same small percentage of patients under the current system where physicians elect whether to participate on the call panel for the ED; and that the vast number of these transfers are for services the Hospital does not currently offer, such as psychiatry, interventional cardiology, and NICU services. This consistency in the data indicates that the shift to a system where physicians elect whether to be on the ED call roster has not changed the Hospital's call capability or increased the need to transfer patients. A majority of those transfers are necessary not because the Hospital does not have emergency coverage for a given specialty, but because the Hospital does not offer the service or procedure the patient needs. As a result of this analysis, the Hospital is taking steps to add identified specialties such as interventional cardiology and a NICU. For these reasons, the Hospital submits that the Hospital was and is in compliance with the rules; and that this citation should be removed.	

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A 150	Continued From page 74 FREQUENCY The frequency and detail of data collection must be specified by the hospital's governing body. This STANDARD is not met as evidenced by: Based on interview and record review, the governing body did not specify the frequency and detail of data collection to monitor the effect of the voluntary call system on patient care. Findings: The minutes of the Governing Body (Board of Governors) were reviewed on May 31, 2007, at 10:10 AM. The minutes from August 2006 contained an entry indicating approval of the voluntary call panel for a trial period of 90 days. The minutes of November 2006 extended the trial period for an additional 90 days. No rationale was given for the continuation of the trial. No data was presented or reviewed regarding the effects that initiation of the voluntary call panel had on hospital departments, staff, or patients. The minutes from January 2007 extended the trial for an additional 6 months, for a total trial period of one year. Again, no supporting data was presented or reviewed. The minutes of the Performance Improvement Committee were reviewed on May 31, 2007, at 11:15 AM. Reviewed minutes spanned from November 2, 2006 to April 5, 2007 (seven months), and included quarterly minutes of the PI Operational Committee. There was no documentation that the trial of voluntary call was ever discussed. There was no evidence of data collection to monitor related patient care	A 150	In addition to the other actions under A186 and A 459, the Governing Body reviewed the CMS Interpretive Guidelines and survey procedures regarding the requirements for ongoing QAPI activities and the responsibility of the Medical Staff with respect to ongoing and continuing assessment of medical care provided in the ED. The Hospital's Governing Body and Medical Executive Committee (MEC) reviewed and confirmed that Medical Staff departments, including the ED Department, regularly review medical care furnished to ED patients. --ED PI activity is completed regularly on specific cases. --Data is trended and monitored regarding the number of ED patients seen and the number of transfers occurring, among other things. --Data is tracked at the ED level, and information is reported up through the ED Department to the MEC, and then to the Governing Body as indicated. --Cases of concern may also be referred to the PI/RM Committee for peer review of unresolved issues/concerns after review by the physician's peers/ department. The Hospital's Governing Body and MEC reviewed and confirmed that the QAPI system was monitoring the completeness of transfer documentation, as noted in the citation.	06/18/07 06/26/07 06/26/07

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A 150	Continued From page 75 indicators in the Emergency Department (ED), the Intensive Care Unit (ICU), or elsewhere in the facility. The PI Director was interviewed on May 31, 2007, at 12:10 PM. She stated that no indicators for monitoring the effects of the trial of voluntary call on patient care were being followed. Physician E was interviewed on May 31, 2007, at 2:30 PM. He was the prior ED director, and sat on both the MEC and the Governing Board. Physician E stated he had "no perception" of any QAPI activities relating to the effects, on patient care, of the institution of voluntary call for specialties in the ED or the ICU. The facility Performance Improvement Plan was reviewed on May 30, 2007. The plan included the following: a. Objectives for provision of care which included: 1. A mechanism to assure that all patients received the same level of care; and 2. A culture where care was delivered in a safe environment, and quality care was measured, monitored and continuously improved. b. The responsibilities of the Governing Board included a duty to assure patient care was safely delivered within the guidelines established by the Medical Staff. c. The Medical Executive Committee of the Medical Staff was accountable to the Governing Board to ensure care was delivered in accordance with the Medical Staff Bylaws, Rules and Regulations.	A 150	The Hospital Governing Body and MEC leadership reviewed and confirmed that participation on the call panel for the ED is not mandatory at this time, but that when a physician agrees to participate on the call panel and is on call for the ED, the physician MUST respond to the Hospital timely when called, MUST come to the Hospital timely to render care when requested, and MUST see all unassigned patients as requested. Administration analyzed transfers for the previous 3 months with a focus on several subspecialties that have little to no coverage, and determined that the majority of transfers were for services the Hospital does not offer (e.g., interventional cardiology, psychiatry, neonatal intensive care (NICU) services), and confirmed that only a very small percentage of transfers occurred because the ED lacked specialist coverage at the time. The Hospital's Governing Body reviewed and confirmed that: --The ED sees approximately 5,000 patients a month; --The ED transfers a very small percentage of those patients because the Hospital maintains 24/7, 365 days/year coverage for multiple specialist categories that address most emergent needs (e.g., Internal Medicine/Family Practice, Pediatrics, OB/Gyn, General Surgery, Trauma Surgery, Orthopedic Surgery, and Anesthesiology), with nearly 24/7, 365 days/year coverage for Cardiology and Neurosurgery (except 2-4 days/month).	6/18/07 06/01/07 06/18/07

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A 150	Continued From page 76 d. Measuring and monitoring performance included ensuring that processes, functions or services were designed/redesigned well, and met the needs of the individuals served. The ED Quality Assurance/Performance Improvement (QAPI) was reviewed on May 30, 2007. The ED was monitoring compliance with EMTALA transfer regulations, on a quarterly basis, in the following areas: a. The patient's condition was documented; b. The accepting facility was documented; c. The accepting physician was documented; d. Appropriate paperwork was sent with the patient; e. The method of transportation was documented; f. Vital signs were done within 15 minutes of transfer; g. The physician defined the reason for transfer; and h. The consent was signed and witnessed. There was no monitoring regarding the reason for transfer, availability of on-call physician services, appropriateness of transfers or outcomes related to transfers. The Medical Staff and Governing Board had no QAPI data to assess the quality of care provided by the on-call physician services in the ED, or to determine if changes in policies were appropriate, necessary and would meet the needs of the individuals served. During an interview with the Director of Performance Improvement (PI) on May 31, 2007, at 12:10 PM, she stated that the issue of not having specialists on call for the ED was discussed "regularly" in the ED committee meetings, and PI was not involved because "we	A 150	--The majority of transfers from the ED are because the patient needs a service the Hospital does not offer, such as interventional cardiology, psychiatry, or neonatal intensive care (NICU) services. --The rate of transfers when physician participation in ED call coverage was mandatory was essentially the same as the rate of transfers under the current system where physicians may elect not to participate on the ED call panel (although as noted above, when a physician elects to take call for the ED, he/she MUST respond to the ED and care for unassigned patients as requested); --The specialties for which there is call coverage have not decreased in the last year, but in fact have increased with the addition of neurosurgery coverage. The "voluntary call" system has been workable because the medical staff has been able to provide 24/7 coverage for almost 365 days/year in the major areas identified above and in A 459; --Administration and Medical Staff leadership are in the process of negotiating further improvements to the call panel to include teleneurology coverage for the ED; a NICU is currently under construction, and interventional cardiology is scheduled to begin construction in 2008. Hospital Administration enhanced the ongoing monitoring of a random sample of transfers to evaluate:	06/29/07

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			--The appropriateness of and reasons for transfers, with attention to transfers because the Hospital does not offer a particular service and because the ED lacks specialist coverage, and --Overall transfer rates. The PI/RM Committee is responsible for analyzing the monitoring results, for taking actions as appropriate, and for reporting information as indicated monthly to the MEC and, as appropriate, to the Governing Body, which meets 10 times during the year. The PI/RM Committee reviewed data on transfers and the reasons for transfer and drew the same conclusions noted above by Administration and the Governing Body. ALLEGATION OF COMPLIANCE: The Hospital nevertheless respectfully disagrees that the citation supports a violation of this rule. Medical and administrative leadership regularly evaluate emergency coverage and anticipated emergency needs on an ongoing basis—as the surveyors saw, this ongoing evaluation is a regular topic of discussion at leadership meetings. The 2567 itself details one of the QAPI monitors used by the Hospital to evaluate transfers. Other monitoring also tracks the number of transfers. The Hospital has determined that it continues to see approximately 5,000 patients a month in	06/29/07 & ongoing 07/09/07

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			the ED; that it transferred a small percentage of its ED patients when there was mandatory call; that it continues to transfer essentially the same small percentage of patients under the current system where physicians elect whether to participate on the call panel for the ED; and that the vast number of these transfers are for services the Hospital does not currently offer, such as psychiatry, interventional cardiology, and NICU services. This consistency in the data indicates that the shift to a system where physicians elect whether to be on the ED call roster has not changed the Hospital's call capability or increased the need to transfer patients. A majority of those transfers are necessary not because the Hospital does not have emergency coverage for a given specialty, but because the Hospital does not offer the service or procedure the patient needs. As a result of this analysis, the Hospital is taking steps to add identified specialties such as interventional cardiology and a NICU. For these reasons, the Hospital submits that the Hospital was and is in compliance with the rules; and that this citation should be removed.	

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	050701	A. BUILDING _____ B. WING _____	C 06/01/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 150	Continued From page 77 already knew we had a problem".	A 150		
A 167	482.21(e) EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring that specific QAPI program requirements are met. This STANDARD is not met as evidenced by: Based on interview and record review, the governing body, administration and medical staff failed to assume full responsibility and accountability for Quality Assurance and Performance Improvement (QAPI) activities to monitor and assess the effect of a change from a mandatory to a voluntary specialty back-up call system. Findings: On May 30, 2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated the practice for the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the Governing Body initially approved the voluntary call system on a trial basis for 90 days, and subsequently extended the trial time on two separate occasions. The current on-call physician coverage for the facility was voluntary. Review of the Medical Staff Bylaws (revised	A 167	In addition to the other actions under A186 and A 459, the Governing Body reviewed the CMS Interpretive Guidelines and survey procedures regarding the requirements for ongoing QAPI activities and the responsibility of the Medical Staff with respect to ongoing and continuing assessment of medical care provided in the ED. The Hospital's Governing Body and Medical Executive Committee (MEC) reviewed and confirmed that Medical Staff departments, including the ED Department, regularly review medical care furnished to ED patients. --ED PI activity is completed regularly on specific cases. --Data is trended and monitored regarding the number of ED patients seen and the number of transfers occurring, among other things. --Data is tracked at the ED level, and information is reported up through the ED Department to the MEC, and then to the Governing Body as indicated. --Cases of concern may also be referred to the PI/RM Committee for peer review of unresolved issues/concerns after review by the physician's peers/ department. The Hospital's Governing Body and MEC reviewed and confirmed that the QAPI	06/18/07 06/26/07 06/26/07

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A 167	Continued From page 78 5/22/06) on May 30, 2007, at 1:45 PM, showed that: a. Section 10.5.3; "A supervisory (departmental) committee shall conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department." b. Section 10.8.5; The duties of department chairs include; "Generally monitor the quality and appropriateness of patient care and professional performance provided by members with clinical privileges in the department ...and oversee the effective conduct of patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee (MEC)," and also, "enforce Medical Staff Bylaws, Rules and Regulations and policies within the department ..." and, "provide for continuous assessment and improvement of the quality of care and services provided." The Performance Improvement (PI) Committee shall "establish systems to identify potential problems in patient care and general areas of potential risk in clinical aspects of patient care and safety." Review of the Medical Staff Rules and Regulations on May 30, 2007, at 1:55 PM, showed that: a. Section 1.3.2; "Each practitioner must be available to provide professional care for his/her patients in a timely manner (30 minutes) or	A 167	system was monitoring the completeness of transfer documentation, as noted in the citation. The Hospital Governing Body and MEC leadership reviewed and confirmed that participation on the call panel for the ED is not mandatory at this time, but that when a physician agrees to participate on the call panel and is on call for the ED, the physician MUST respond to the Hospital timely when called, MUST come to the Hospital timely to render care when requested, and MUST see all unassigned patients as requested. Administration analyzed transfers for the previous 3 months with a focus on several subspecialties that have little to no coverage, and determined that the majority of transfers were for services the Hospital does not offer (e.g., interventional cardiology, psychiatry, neonatal intensive care (NICU) services), and confirmed that only a very small percentage of transfers occurred because the ED lacked specialist coverage at the time. The Hospital's Governing Body reviewed and confirmed that: --The ED sees approximately 5,000 patients a month; --The ED transfers a very small percentage of those patients because the Hospital maintains 24/7, 365 days/year coverage for multiple specialist categories that address most emergent needs (e.g., Internal Medicine/Family Practice,	06/18/07 06/01/07 06/18/07

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A 167	Continued From page 79 arrange for an alternate practitioner who has equivalent clinical privileges at the Hospital." b. Section 1.10.8; Regarding care in the Intensive Care Unit (ICU), "consultation by the appropriate specialty is required for ...Fulminant Hepatic Failure and GI Bleed (gastroenterology), patients on mechanical ventilation (Pulmonary) ...Renal Failure requiring dialysis (Nephrology), Suicide attempt requiring a 5150 or a 72-hour hold (psychiatry) ...Status Epilepticus and CVA (neurology)." Regarding the call panel. "Service on the call panel is not a privilege, but is an obligation of staff membership. Practitioners on call must respond promptly when requested to see a patient. The practitioner must be available to respond in person to the emergency within 30 minutes if requested. The panelist is responsible for arranging coverage if he/she is not available. ...Each practitioner shall accept the care of all patients who are appropriately referred without discrimination ... The on call specialist must also be available for inpatients ....it means that if no other specialist in that specialty is willing or able ...the on call specialist has the obligation to see that patient ..." The minutes of the Governing Body (Board of Governors) were reviewed on May 31, 2007, at 10:10 AM. The minutes from August 2006 contained an entry indicating approval of the voluntary call panel for a trial period of 90 days. The minutes of November 2006 extended the trial period for an additional 90 days. No rationale was given for the continuation of the trial. No data was presented or reviewed regarding the effects that initiation of the voluntary call panel had on hospital departments, staff, or patients. The minutes from January 2007 extended the trial	A 167	Pediatrics, OB/Gyn, General Surgery, Trauma Surgery, Orthopedic Surgery, and Anesthesiology), and nearly 24/7, 365 days/year coverage for Cardiology and Neurosurgery (except 2-4 days/month). --The majority of transfers from the ED are because the patient needs a service the Hospital does not offer, such as interventional cardiology, psychiatry, or neonatal intensive care (NICU) services. --The rate of transfers when physician participation in ED call coverage was mandatory was essentially the same as the rate of transfers under the current system where physicians may elect not to participate on the ED call panel (although as noted above, when a physician elects to take call for the ED, he/she MUST respond to the ED and care for unassigned patients as requested); --The specialties for which there is call coverage have not decreased in the last year, but in fact have increased with the addition of neurosurgery coverage. The "voluntary call" system has been workable because the medical staff has been able to provide 24/7 coverage for almost 365 days/year in the major areas identified above and in A 459; --Administration and Medical Staff leadership are in the process of negotiating further improvements to the call panel to include teleneurology coverage for the ED; a NICU is currently under construction, and interventional cardiology is scheduled to begin construction in 2008.	

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A 167	Continued From page 80 for an additional 6 months, for a total trial period of one year. Again, no supporting data was presented or reviewed. The minutes of the Performance Improvement Committee were reviewed on May 31, 2007, at 11:15 AM. Reviewed minutes spanned from November 2, 2006 to April 5, 2007 (seven months), and included quarterly minutes of the PI Operational Committee. There was no documentation that the trial of voluntary call was ever discussed. There was no evidence of data collection to monitor related patient care indicators in the Emergency Department (ED), the ICU, or elsewhere in the facility. The PI Director was interviewed on May 31, 2007, at 12:10 PM. She stated that no indicators for monitoring the effects of the trial of voluntary call on patient care were being followed. Physician E was interviewed on May 31, 2007, at 2:30 PM. He was the prior ED director, and sat on both the MEC and the Governing Board. Physician E stated he had "no perception" of any QAPI activities relating to the effects, on patient care, of the institution of voluntary call for specialties in the ED or the ICU. The facility Performance Improvement Plan was reviewed on May 30, 2007. The plan included the following: a. Objectives for provision of care which included: 1. A mechanism to assure that all patients received the same level of care; and 2. A culture where care was delivered in a safe environment, and quality care was measured, monitored and continuously improved.	A 167	Hospital Administration enhanced the ongoing monitoring of a random sample of transfers to evaluate: --The appropriateness of and reasons for transfers, with attention to transfers because the Hospital does not offer a particular service and because the ED lacks specialist coverage, and --Overall transfer rates. The PI/RM Committee is responsible for analyzing the monitoring results, for taking actions as appropriate, and for reporting information as indicated monthly to the MEC and, as appropriate, to the Governing Body, which meets 10 times during the year. The PI/RM Committee reviewed data on transfers and the reasons for transfer and drew the same conclusions noted above by Administration and the Governing Body. ALLEGATION OF COMPLIANCE: The Hospital nevertheless respectfully disagrees that the citation supports a violation of this rule. Medical and administrative leadership regularly evaluate emergency coverage and anticipated emergency needs on an ongoing basis—as the surveyors saw, this ongoing evaluation is a regular topic of discussion at leadership meetings. The 2567 itself details one of the QAPI monitors used by the Hospital to evaluate transfers. Other monitoring also tracks the	06/29/07 06/29/07 & ongoing 07/09/07

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A 167	Continued From page 81 b. The responsibilities of the Governing Board included a duty to assure patient care was safely delivered within the guidelines established by the Medical Staff. c. The Medical Executive Committee of the Medical Staff was accountable to the Governing Board to ensure care was delivered in accordance with the Medical Staff Bylaws, Rules and Regulations. d. Measuring and monitoring performance included ensuring that processes, functions or services were designed/redesigned well, and met the needs of the individuals served. The ED Quality Assurance/Performance Improvement (QAPI) was reviewed on May 30, 2007. The ED was monitoring compliance with EMTALA transfer regulations, on a quarterly basis, in the following areas: a. The patient's condition was documented; b. The accepting facility was documented; c. The accepting physician was documented; d. Appropriate paperwork was sent with the patient; e. The method of transportation was documented; f. Vital signs were done within 15 minutes of transfer; g. The physician defined the reason for transfer; and h. The consent was signed and witnessed. There was no monitoring regarding the reason for transfer, availability of on-call physician services, appropriateness of transfers or outcomes related to transfers. The Medical Staff and Governing	A 167	number of transfers. The Hospital has determined that it continues to see approximately 5,000 patients a month in the ED; that it transferred a small percentage of its ED patients when there was mandatory call; that it continues to transfer essentially the same small percentage of patients under the current system where physicians elect whether to participate on the call panel for the ED; and that the vast number of these transfers are for services the Hospital does not currently offer, such as psychiatry, interventional cardiology, and NICU services. This consistency in the data indicates that the shift to a system where physicians elect whether to be on the ED call roster has not changed the Hospital's call capability or increased the need to transfer patients. A majority of those transfers are necessary not because the Hospital does not have emergency coverage for a given specialty, but because the Hospital does not offer the service or procedure the patient needs. As a result of this analysis, the Hospital is taking steps to add identified specialties such as interventional cardiology and a NICU. For these reasons, the Hospital submits that the Hospital was and is in compliance with the rules; and that this citation should be removed.	

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A 167	Continued From page 82 Board had no QAPI data to assess the quality of care provided by the on-call physician services in the ED, or to determine if changes in policies were appropriate, necessary and would meet the needs of the individuals served. During an interview with the Director of Performance Improvement (PI) on May 31, 2007, at 12:10 PM, she stated that the issue of not having specialists on call for the ED was discussed "regularly" in the ED committee meetings, and PI was not involved because "we already knew we had a problem".	A 167		
A 169	482.21(e)(1) EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring that an ongoing program for patient safety, including the reduction of medical errors, is defined, implemented and maintained. This STANDARD is not met as evidenced by: Based on interview and record review, the Governing Body, Administration and Medical Staff failed to ensure that the facility QAPI efforts included an ongoing program for patient safety in the nine month period following the adoption of a voluntary specialty emergency back-up call system. Findings: Review of the Medical Staff Bylaws (revised 5/22/06) on May 30, 2007, at 1:45 PM, showed	A 169	In addition to the other actions under A186 and A 459, the Governing Body reviewed the CMS Interpretive Guidelines and survey procedures regarding the requirements for ongoing QAPI activities and the responsibility of the Medical Staff with respect to ongoing and continuing assessment of medical care provided in the ED. The Hospital's Governing Body and Medical Executive Committee (MEC) reviewed and confirmed that Medical Staff departments, including the ED Department, regularly review medical care furnished to ED patients. --ED PI activity is completed regularly on specific cases. --Data is trended and monitored regarding the number of ED patients seen and the number of transfers occurring, among other things.	06/18/07 06/26/07

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A 169	Continued From page 83 that: a. Section 10.5.3; "A supervisory (departmental) committee shall conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department." b. Section 10.8.5; The duties of department chairs include; "Generally monitor the quality and appropriateness of patient care and professional performance provided by members with clinical privileges in the department ...and oversee the effective conduct of patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee (MEC)," and also, "enforce Medical Staff Bylaws, Rules and Regulations and policies within the department ..." and, "provide for continuous assessment and improvement of the quality of care and services provided." The Performance Improvement (PI) Committee shall "establish systems to identify potential problems in patient care and general areas of potential risk in clinical aspects of patient care and safety." The minutes of the Performance Improvement Committee were reviewed on May 31, 2007, at 11:15 AM. Reviewed minutes spanned from November 2, 2006 to April 5, 2007 (seven months), and included quarterly minutes of the PI Operational Committee. There was no documentation that the trial of voluntary call was ever discussed. There was no evidence of data	A 169	--Data is tracked at the ED level, and information is reported up through the ED Department to the MEC, and then to the Governing Body as indicated. --Cases of concern may also be referred to the PI/RM Committee for peer review of unresolved issues/concerns after review by the physician's peers/ department. The Hospital's Governing Body and MEC reviewed and confirmed that the QAPI system was monitoring the completeness of transfer documentation, as noted in the citation. The Hospital Governing Body and MEC leadership reviewed and confirmed that participation on the call panel for the ED is not mandatory at this time, but that when a physician agrees to participate on the call panel and is on call for the ED, the physician MUST respond to the Hospital timely when called, MUST come to the Hospital timely to render care when requested, and MUST see all unassigned patients as requested. Administration analyzed transfers for the previous 3 months with a focus on several subspecialties that have little to no coverage, and determined that the majority of transfers were for services the Hospital does not offer (e.g., interventional cardiology, psychiatry, neonatal intensive care (NICU) services), and confirmed that only a very small percentage of transfers occurred because the ED lacked specialist coverage at the time.	06/26/07 06/18/07 06/01/07

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A 169	Continued From page 84 collection to monitor related patient care indicators in the Emergency Department (ED), the Intensive Care Unit (ICU), or elsewhere in the facility. The PI Director was interviewed on May 31, 2007, at 12:10 PM. She stated that no indicators for monitoring the effects of the trial of voluntary call on patient care were being followed. Physician E was interviewed on May 31, 2007, at 2:30 PM. He was the prior ED director, and sat on both the MEC and the Governing Board. Physician E stated he had "no perception" of any QAPI activities relating to the effects, on patient care, of the institution of voluntary call for specialties in the ED or the ICU. The facility Performance Improvement Plan was reviewed on May 30, 2007. The plan included the following: a. Objectives for provision of care which included: 1. A mechanism to assure that all patients received the same level of care; and 2. A culture where care was delivered in a safe environment, and quality care was measured, monitored and continuously improved. b. The responsibilities of the Governing Board included a duty to assure patient care was safely delivered within the guidelines established by the Medical Staff. c. The Medical Executive Committee of the Medical Staff was accountable to the Governing Board to ensure care was delivered in accordance with the Medical Staff Bylaws, Rules and Regulations.	A 169	The Hospital's Governing Body reviewed and confirmed that: --The ED sees approximately 5,000 patients a month; --The ED transfers a very small percentage of those patients because the Hospital maintains 24/7, 365 days/year coverage for multiple specialist categories that address most emergent needs (e.g., Internal Medicine/Family Practice, Pediatrics, OB/Gyn, General Surgery, Trauma Surgery, Orthopedic Surgery, and Anesthesiology), and nearly 24/7, 365 days/year coverage for Cardiology and Neurosurgery (except 2-4 days/month), --The majority of transfers from the ED are because the patient needs a service the Hospital does not offer, such as interventional cardiology, psychiatry, or neonatal intensive care (NICU) services. --The rate of transfers when physician participation in ED call coverage was mandatory was essentially the same as the rate of transfers under the current system where physicians may elect not to participate on the ED call panel (although as noted above, when a physician elects to take call for the ED, he/she MUST respond to the ED and care for unassigned patients as requested); --The specialties for which there is call coverage have not decreased in the last year, but in fact have increased with the addition of neurosurgery coverage. The "voluntary call" system has been workable because the medical staff has been able to provide 24/7 coverage for almost 365	06/18/07

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A 169	Continued From page 85 d. Measuring and monitoring performance included ensuring that processes, functions or services were designed/redesigned well, and met the needs of the individuals served. The ED Quality Assurance/Performance Improvement (QAPI) was reviewed on May 30, 2007. The ED was monitoring compliance with EMTALA transfer regulations, on a quarterly basis, in the following areas: a. The patient's condition was documented; b. The accepting facility was documented; c. The accepting physician was documented; d. Appropriate paperwork was sent with the patient; e. The method of transportation was documented; f. Vital signs were done within 15 minutes of transfer; g. The physician defined the reason for transfer; and h. The consent was signed and witnessed. There was no monitoring regarding the reason for transfer, availability of on-call physician services, appropriateness of transfers or outcomes related to transfers. The Medical Staff and Governing Board had no QAPI data to assess the quality of care provided by the on-call physician services in the ED, or to determine if changes in policies were appropriate, necessary and would meet the needs of the individuals served. During an interview with the Director of Performance Improvement (PI) on May 31, 2007, at 12:10 PM, she stated that the issue of not having specialists on call for the ED was discussed "regularly" in the ED committee	A 169	days/year in the major areas identified above and in A 459; --Administration and Medical Staff leadership are in the process of negotiating further improvements to the call panel to include teleneurology coverage for the ED; a NICU is currently under construction, and interventional cardiology is scheduled to begin construction in 2008. Hospital Administration enhanced the ongoing monitoring of a random sample of transfers to evaluate: --The appropriateness of and reasons for transfers, with attention to transfers because the Hospital does not offer a particular service and because the ED lacks specialist coverage, and --Overall transfer rates. The PI/RM Committee is responsible for analyzing the monitoring results, for taking actions as appropriate, and for reporting information as indicated monthly to the MEC and, as appropriate, to the Governing Body, which meets 10 times during the year. 07/09/07 The PI/RM Committee reviewed data on transfers and the reasons for transfer and drew the same conclusions noted above by Administration and the Governing Body. cont. next page	06/29/07 06/29/07 & ongoing 07/09/07

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			ALLEGATION OF COMPLIANCE: The Hospital nevertheless respectfully disagrees that the citation supports a violation of this rule. Medical and administrative leadership regularly evaluate emergency coverage and anticipated emergency needs on an ongoing basis—as the surveyors saw, this ongoing evaluation is a regular topic of discussion at leadership meetings. The 2567 itself details one of the QAPI monitors used by the Hospital to evaluate transfers. Other monitoring also tracks the number of transfers. The Hospital has determined that it continues to see approximately 5,000 patients a month in the ED; that it transferred a small percentage of its ED patients when there was mandatory call; that it continues to transfer essentially the same small percentage of patients under the current system where physicians elect whether to participate on the call panel for the ED; and that the vast number of these transfers are for services the Hospital does not currently offer, such as psychiatry, interventional cardiology, and NICU services. This consistency in the data indicates that the shift to a system where physicians elect whether to be on the ED call roster has not changed the Hospital's call capability or increased the need to transfer patients. A majority of those transfers are necessary not because the Hospital does not have emergency coverage for a given specialty, but because the Hospital does	

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			not offer the service or procedure the patient needs. As a result of this analysis, the Hospital is taking steps to add identified specialties such as interventional cardiology and a NICU. For these reasons, the Hospital submits that the Hospital was and is in compliance with the rules; and that this citation should be removed.	

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A 169	Continued From page 86 meetings, and PI was not involved because "we already knew we had a problem".	A 169		
A 181	482.22 MEDICAL STAFF The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of care provided to patients by the hospital. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the Medical Staff members operated under bylaws that were approved by the Governing Body and were responsible for the quality of medical care provided to patients by failure to ensure that: 1. The Medical Staff members were accountable to the Governing Body for the provision of on-call physician coverage for the Emergency Department and Intensive Care Unit for specialty medical services that were provided by the facility (A185). 2. The Medical Staff enforced its adopted bylaws to ensure that the responsibilities of all the Medical Staff members were carried out (A186). The cumulative effect of the deficient practices resulted in the failure of the facility to ensure the delivery of quality medical care to patients.	A 181	Please see actions taken under Tags A 185 and A 186.	
A 185	482.22(b) MED STAFF ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. The medical staff must be organized in a manner	A 185	In addition to actions detailed under A 186 with respect to inpatients, the Hospital has taken the following actions with respect to emergency services furnished in the ED: Regarding current call coverage for the Hospital ED, the Governing Body	06/18/07

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A 185	Continued From page 87 approved by the governing body. If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy. The responsibility for organization and conduct of the medical staff must be assigned only to an individual doctor of medicine or osteopathy or, when permitted by State law of the State in which the hospital is located, a doctor of dental surgery or dental medicine. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the medical staff was accountable to the Governing Body for the provision of on-call physician services for eight of 55 patients at IVMC (Patients 105, 118, 119, 120, 121, 122, 124 and 129), and seven of 68 patients at RSMC (Patients 31, 36, 40, 203, 204, 205 and 206) for the Emergency Department (ED), and three of seven patients at IVMC (Patients 135, 201 and 202), and one of two patients at RSMC (Patient 44) for the Intensive Care Unit (ICU), for specialty medical services provided by the facility, as approved by the Governing Body. Several medical specialties, normally available at the hospitals, failed to provide emergency back-up call or on-call services for hospitalized patients. This resulted in delays in care, unnecessary transfers, and unsafe transfers for ED patients. Care in the ICU was affected due to the lack of 24 hour coverage of ventilator-dependent patients by staff pulmonologists.	A 185	considered the Medicare Interpretive Guidelines and Survey procedures concerning the Emergency Services Condition of Participation and of the more specific EMTALA rules, and reviewed the anticipated emergency needs of the Hospital's patients. The Governing Body reviewed and confirmed the staffing of the ED with appropriate personnel and with ED physicians qualified to handle most emergencies. The Governing Body revisited the following key factors with respect to the Hospital's staffing of the on-call roster for the ED: --What specialties met the most frequent needs for emergency services and the fact that these specialties should be scheduled to be on call for the ED as close to 24/7, 365 days/year as possible. These specialties are: medicine/family practice, general surgery, orthopedics, obstetrics/gynecology, cardiology, trauma surgery, neurosurgery, pediatrics, and anesthesiology; --What services and facilities the Hospital offered, including the services and facilities the Hospital did not offer (e.g., the fact that the Hospital does not have a psychiatric unit, a NICU, interventional cardiology, or the specialized equipment to perform complex opthalmology procedures such as the surgery to repair retinal detachment); --The types of emergency services that	06/18/07 06/18/07 & 07/03/07

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A 185	Continued From page 88 Findings at IVMC: On May 30, 2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated the practice for the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the Governing Body initially approved the voluntary call system on a trial basis for 90 days, and subsequently extended the trial time on two separate occasions. The current on-call physician coverage for the facility was voluntary. A review of the Medical Staff Bylaws, for IVMC and RSMC, on May 30, 2007, showed that "Each active medical staff member shall actively participate on, and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including but not limited to emergency services and back-up functions....and, Provisional staff members seeking Active staff membership shall serve on the on-call panels appropriate to Active staff members." A review of the Medical Staff Rules and Regulations, for IVMC and RSMC, on May 30, 2007, showed that: Section 1.3.2; "Each practitioner must be available to provide professional care for his/her patients in a timely manner (30 minutes) or arrange for an alternate practitioner who has equivalent clinical privileges at the hospital." Section 2.1.1; "A call panel has been established for referring patients who need hospital care to	A 185	the emergency physicians can provide without the need for a specialty consult or specialty evaluation in the ED because they have the training and experience to provide them, with the assistance of internists/family practitioners, orthopedists, and surgeons who are on call for the ED 24/7, 365 days/year. Such services include, e.g., allergy, dermatology, podiatry, radiation/oncology, hematology/oncology, etc.; -- The number of physicians on staff, including the number on active staff in each specialty who have committed to provide on-call coverage for the ED; --Other demands on these physicians (practice and surgery schedules, participation in medical staff leadership activities, peer review activities, utilization review, vacations, requirements to obtain continuing medical education, etc.); --The frequency with which the Hospital's patients typically require services of certain specialists in the ED; --The provisions the Hospital has made for situations in which a physician in a particular specialty is not on call or the on-call physician is unable to respond. Such provisions include: * The ability to have a general surgeon, trauma surgeon, orthopedic surgeon, obstetrician, pediatrician, neurosurgeon, family practitioner, internist, or hospitalist admit the patient to render	

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A 185	Continued From page 89 qualified medical staff members. Service on the call panel is not a privilege, but is an obligation of staff membership." Section 2.2.1; "Practitioners on call must respond promptly when requested to see a patient. Practitioners, including specialty consultants, must respond initially by phone or in person within approximately 30 minutes of the time the request to respond is made." Section 2.2.3; "When scheduled on call, each practitioner shall accept the care of all patients who are appropriately referred..." Section 2.2.4; "The on call specialist must also be available for inpatients. If no other specialist in that specialty is willing or able to provide care for a particular inpatient, the on call specialist has the obligation to see that patient to treat, stabilize or appropriately transfer the patient in a timely manner." Section 2.2.7; "A patient will be admitted in the name of the call panel practitioner. The call panel practitioner must be notified about each admission to his service prior to the patient leaving the Emergency Department, and following a discussion with the Emergency Department physician." During a review of ICU medical records on May 30, May 31 and June 1, 2007, the following was noted: a. Patient 135, a 66 year old male, was admitted to the ICU on May 29, 2007, after an emergency tracheostomy (a tube placed to assist with breathing) was performed in the ED. According	A 185	appropriate care, * If a transfer is necessary, having readily available to ED staff a prioritized list of other facilities that are capable of handling various conditions so the ED immediately calls appropriate facilities to seek a transfer, and * Having transfer agreements in place with a number of other facilities to streamline transfer arrangements if those facilities are the appropriate places to send the patient. Hospital Administration and Governing Body members noted that: --CMS recognizes that the Hospital "has the discretion to maintain the on-call list in a manner that best meets the needs of the hospital's patients who are receiving services required under EMTALA" in accordance with the resources available to the hospital, including the availability of on-call physicians. --While CMS recognizes that it is a best practice that the particular services a hospital offers to the public should be available through on-call coverage of the ED, CMS also recognizes that a hospital is not required to have 24/7 coverage in all specialties, and that implementing such coverage in some specialties (e.g., allergy or certain subspecialties with very few physicians) would detract from the availability of the most needed specialists, such as internists/family practitioners, general surgeons, orthopedists, trauma	06/18/07

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A 185	Continued From page 90 to the ICU nurses notes, on May 29, 2007, at 9:30 PM, Patient 135 became agitated and was fighting the ventilator (breathing machine). The ICU nurse paged the patient's primary physician and the pulmonologist for assistance in managing the patient. Neither of these physicians responded to their pages. b. Patient 201, a 76-year-old male was admitted to the ICU on May 24, 2007, with a preliminary diagnosis of Epidural Abscess (collection of pus near the spinal cord). A neurology consultation, dated May 24, 2007, was handwritten in the physician's progress notes. A transcribed, dictated and very detailed neurology consultation was in the medical record, also dated May 24, 2007. The transcribed consultation note was identified as being performed by Physician A. At the end of the dictated consultation, Physician A noted that he would be going out of town, and had notified the admitting physician. c. Patient 202, an elderly gentleman with left-sided weakness and pneumonia was hospitalized in ICU at IVMC during the time of the survey. On May 31, 2007, at 8:15 AM, Patient 202 suffered a deterioration of his respiratory status. The nurses notes contained the timeline of events. Physician H, a neurologist, was at the bedside of Patient 202 when the nurses called Physician F, a Pulmonologist/Intensivist, also Medical Director for Respiratory Services, for assistance with an emergency intubation (placement of a breathing tube into the lungs). According to the nurses notes, Physician F was unavailable to come to the hospital. The nurses then paged Physician I to assist with an emergency intubation. Physician I was also a Pulmonary/Critical Care specialist, although he	A 185	surgeons, neurosurgeons, pediatricians, OB/GYN specialists, and cardiologists. Administration and ED Physician Leadership reviewed and confirmed there was call coverage for the following specialties, and noted that the citation is mistaken when it says that the Hospital does not have call coverage for neurology and pulmonology, which are provided as follows: --Anesthesiology (on call 24/7, 365 days/year) --Internal Medicine/Family Practice (on call 24/7, 365 days/year) --Pediatrics (on call 24/7, 365 days/year) --OB/Gyn (on call 24/7, 365 days/year) --General Surgery (on call 24/7, 365 days/year) --Orthopedic Surgery (on call 24/7, 365 days/year) --Trauma Surgery (on call 24/7, 365 days/year) --Neurosurgery (on call 24/7 for all but 2-4 days each month) --Cardiology (on call 24/7, nearly 365 days/year) --Neurology (currently on call 24/7 for 7 days a month, with efforts underway to add teleneurology on an expedited basis to provide 24/7 coverage for the rest of each month) --Pulmonology (24/7 for 7 days a month, and because most pulmonary emergencies involve managing patients on a ventilator, a combination of pulmonologists and internists newly credentialed to managed ventilator patients enables additional on call coverage for ventilator patients 24/7 for 20+ days per month, with a goal of coverage	07/02/07

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A 185	Continued From page 91 was not listed on the on-call schedule. The nurses informed Physician I that the patient required emergency intubation, but he was unavailable to come to the hospital at that time. A code blue (patient needing the resuscitation team) was called and Physician J, an ED physician, responded and intubated the patient at approximately 9:05 AM, 50 minutes after the patient was identified to be in severe respiratory distress requiring mechanical ventilation (breathing machine). During an interview with ICU RN 1 on May 30, 2007, at 9:50 AM, she stated that the pulmonologists took call for their own patients during the week, and the on-call pulmonologist covered on the weekends. When she was asked what they did when there was no pulmonologist on call due to the "voluntary" call system, she stated that they called the ED to see if there was somebody on call, and if not, they called all of the pulmonologists on staff until they found one that was available to help them. During an interview with the Director of ICU on May 31, 2007, at 10:20 AM, she stated that she got feedback, from the nurses, for all of the problems that arose in the ICU. According to the Director, the ICU nurses were having a great deal of difficulty getting a pulmonologist to assist with ventilator management up until approximately two months ago. The Director stated with the addition of a new pulmonologist, the problem had improved. She stated she received approximately two calls per month from the ICU nursing staff related to this problem. She stated that when the ICU staff needed to know who was on call for a specialty, they usually knew by "word of mouth." If not, they called the ED for	A 185	nearly every day) --Vascular Surgery (covered by a specific vascular surgeon when scheduled on Trauma Surgery call panel) Administration and ED Physician Leadership reviewed the specialties not covered by the ED call panel or where there are gaps in coverage, confirmed that it would not be appropriate for some specialties to take call because they do not typically treat emergencies, and therefore identified the appropriate practitioners who provide coverage and who are qualified to assess and provide stabilizing treatment for ED patients with emergencies: --Allergy: ED physicians on site 24/7 for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365 days/year; allergists do not usually handle emergencies --Dentistry: See Oral Surgery; the only dentist on staff practices general dentistry, and any dental emergencies are actually oral surgery issues --Dermatology: ED physicians on site 24/7 for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365 days/year (to the extent a patient may have a dermatological emergency) --Dermatology: ED physicians on site 24/7 for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365 days/year (to the extent a patient may have a dermatological emergency) --Endocrinology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year	07/02/07

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A 185	Continued From page 92 information. If the ED could not help, they called the offices for that particular specialty and inquired. If the offices didn't know, they went "down the list" and called all of the physicians in that specialty to see if they could get assistance. If they were still unable to get a specialist, they called the ICU Medical Director. The ICU Director stated that when the nursing staff had a delay in getting a response from a physician, they were supposed to write an HPRR (Healthcare Peer Review Report), that was reviewed and investigated by the clinical lead, and forwarded to the Performance Improvement Department. The ICU staff meeting minutes, dated April 19, 2007, were reviewed on May 31, 2007, at 10:50 AM. Under Department Issues, there was a discussion regarding "nurse apathy". The first causative factor of nurse apathy was listed as "MD's do not seem to have accountability, do not answer pages, pass the buck, change phone numbers constantly". During an interview with ICU RN 2 on May 31, 2007, at 11:05 AM, ICU RN 2 stated that she remembered the April 19 staff meeting when the physician accountability was discussed. ICU RN 2 stated that if they need a specialist, they usually "just know who to call". If they did not know, ICU RN 2 stated, "we sometimes have to call all of the doctors on the list for that specialty". She stated that the problem had not improved yet. During an interview with ICU RN 3 on May 31, 2007, at 11:15 AM, ICU RN 3 stated that she remembered the April 19 staff meeting where the physician accountability was discussed. ICU RN 3 stated that the problem was worse for the night shift, and on the weekends. She stated that the	A 185	--Gastroenterology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Hematology/Oncology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Infectious Diseases: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Nephrology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Neurology (when there is a gap in coverage): ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year, and Neurosurgeons on call 24/7 for all but 2-4 days/month --Ophthalmology: ED physicians on site 24/7 for 365 days/year; the Hospital does not offer complex ophthalmological surgeries because it does not have the necessary specialized equipment --Oral Surgery: ED physicians on site 24/7 for 365 days/year --Pain Management: ED physicians on site 24/7 for 365 days/year, Internists/ Family Practitioners on call 24/7 for 365 days/year --Plastic Surgery: ED physicians on site 24/7 for 365 days/year, and General	

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A 185	Continued From page 93 nurses got tired and frustrated, and "we just want to take care of our patients, and the doctors don't care". ICU RN 3 stated that she had completed HPRR's regarding her inability to reach the physicians. The Director of Respiratory Services was interviewed on May 31, 2007 at 3:25 PM. He stated that in the event a patient on a ventilator needed a change in the machine settings, the pulmonologist on call would be contacted. If there was no pulmonologist on call, or if there was no response to a page, the respiratory therapist would call their Medical Director, Physician F. Physician F is board certified in Pulmonology and in Critical Care. If he was not available, then the "chain of command" was initiated. During a review of ED medical records on May 30 and May 31, 2007, the following was noted: a. Patient 105, a 77 year old female, presented to the ED on March 2, 2007, at 12:36 PM, with a chief complaint of "sent by primary doctor for possible stroke." The triage assessment, completed on March 2, 2007, at 1:05 PM, showed that Patient 105 had a headache, depression, was tired and had a droopy left eye. In the ED, a Computerized Tomography (CT) scan of the head revealed a 7 x 12 mm area of bleeding in the intraparenchymal space (inside of the brain). The ED physician's dictated report dated March 2, 2007, showed that the neurosurgeon on staff was paged, and spoken to at home, but "he does not take call within our hospital, he is out of town and is not available." The ED physician made arrangements to transfer Patient 105 to another facility for a "higher level of care." The ED physician then contacted the house supervisor,	A 185	--Podiatry: ED physicians on site 24/7 for 365 days/year, Orthopedic Surgeons on call 24/7 for 365 days/year --Psychiatry: Not a service offered by the Hospital because the Hospital does not have a psychiatric unit --Pulmonology: ED physicians on site 24/7 for 365 days/year, Pulmonologists on call 24/7 for 7 days a month, and Internists credentialed to manage patients on ventilators on call 24/7 for most of the remaining 23-24 days per month --Radiation/Oncology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Rheumatology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Urology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Vascular Surgery: Covered 24/7 for several days a month by a specific vascular surgeon when scheduled on the Trauma Surgery call panel Administration and ED Physician Leadership developed a grid to facilitate provision of care by on-call specialists and, when a transfer is necessary, to streamline the arrangements for transfer.	07/03/07

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A 185	Continued From page 94 "and informed her of the transfer situation...and spoke to the hospital administrator and informed her of the situation, that the patient will be transferred for a higher level of care, as there is no neurosurgical call panel here." Patient 105 was transferred to another facility for neurosurgical services at 11:20 PM, nearly 11 hours after arriving in the ED for treatment. A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two neurosurgeons on active staff. A review of the ED on-call schedule on May 31, 2007, showed that only one neurosurgeon was taking call. b. Patient 118, a 33 year old male, presented to the ED on March 4, 2007, at 2:03 PM, with a chief complaint of an injury to the left leg. An x-ray of the left tibia and fibula showed a "closed comminuted displaced fracture of the left tib-fib" (tibia and fibula). A review of the ED physician's notes showed that "multiple calls were made to the orthopedic physician on call, with no answer." The ED physician transferred Patient 118 to another facility for orthopedic care. c. Patient 119, a 26 year old male, presented to the ED on March 27, 2007, at 10:10 AM, with a chief complaint of multiple seizures after arriving in the recovery room at a local surgery center. Patient 119 continued to have seizures while being transported to the ED by ambulance, and on arrival in the ED. The ED physician diagnosed Patient 119 with Status Epilepticus (uncontrolled seizures). The ED physician's dictated report, dated March 27, 2007, showed that Patient 119 and his family were informed of the treatment	A 185	Specifically, the grid guides ED staff in calling the appropriate on-call specialist for ED patients, and in calling the hospitals capable of furnishing the specialty care that the patient needs and that the Hospital cannot provide at that time. Administration and ED Physician Leadership reviewed and revised the ED on-call list so that all pertinent information about what physicians are on call appears on one page. Administration and the Chair of the PI/RM Committee circulated the grid and revised on-call list to ED staff with a memorandum confirming use of the on-call list and of the grid. Administration clarified that ED staff must contact the appropriate specialist listed on the on-call roster when needed to assess/treat a patient with a possible emergency, rather than calling physicians who are NOT on call. Administration reviewed and clarified that ED staff should arrange for an appropriate transfer when the appropriate on-call specialist is not available, there is a gap in coverage for the ED, the patient requires services the Hospital does not provide, or the patient needs a higher level of care. ED Leadership met with ED staff to discuss the system for using the on-call list and the grid to obtain appropriate emergency care for ED patients in a timely fashion.	07/03/07 07/03/07 07/03/07 07/03/07

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 185	Continued From page 95 plan, "including the potential for transfer to a tertiary care center for neurology, as we have no neurology on-call." The ED physician, "spoke to a staff neurologist, however he was not on call, and agreed with the plan to transfer." The ED physician arranged for Patient 119 to be transferred to another facility, accompanied by a critical care transport team, for neurology care. A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two neurologists on active staff, and two neurologists in provisional status seeking active staff membership. d. Patient 120, a 62 year old male, presented to the ED on April 2, 2007, at 11:58 PM, with a chief complaint of blindness in the right eye. The triage assessment, completed on April 3, 2007, at 12:24 AM, showed that Patient 120 had a sudden onset of loss of vision in his right eye at 10:30 PM, after hitting his head earlier in the day. The ED physician's dictated report, dated April 3, 2007, showed that Patient 120 had signs of a retinal detachment and, "this institution does not have an ophthalmologist on call." Patient 120 was transferred to another facility for a "higher level of ophthalmological care," at 7:43 AM, nearly eight hours after arrival in the ED for treatment. A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two ophthalmologists on active staff, and one ophthalmologist in provisional status seeking active staff membership. e. Patient 121, a 54 year old female, presented to the ED on April 28, 2007, with a chief complaint of vomiting blood. The ED physician's notes	A 185	The CEO and COO are negotiating a contract for teleneurology to be available to the ED 24/7 for all days where there is no neurology coverage, with a projected launch of the system by sometime in fall 2007. Through teleneurology, the ED will have the benefit of neurologists reading tests and ordering appropriate treatment for neurological problems that require prompt treatment (such as administration of TPA). Administration is negotiating to add interventional cardiology as a Hospital service that would be available to both ED patients and hospital inpatients. Administration has initiated the process for adding a NICU, which would be available to both ED patients and hospital inpatients. The Governing Body reviewed and confirmed that the adoption of the voluntary call system did not diminish the availability of emergency services to patients. The Governing Body reviewed the overall rate of transfers out of the ED before and after the implementation of the current call system for the ED. Most significantly, the overall rate of transfers (calculated by dividing the number of transfers by the number of emergency visits for each month) has remained essentially the same, and most of the transfers are done because the patients need services the Hospital does not currently provide (such as psychiatry, interventional cardiology, and NICU services).	In process In process Under construc-tion 06/18/07

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	050701	A. BUILDING _____ B. WING _____	C 06/01/2007

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SOUTHWEST HEALTHCARE SYSTEM	25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562

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A 185	Continued From page 96 showed that the patient was transferred to another facility for a "higher level of care, no GI (Gastroenterology) service on call." A review of the Medical Staff Roster on May 31, 2007, showed that the facility had six gastroenterologists on active staff. f. Patient 122, a 17 year old male, presented to the ED on April 2, 2007, at 1:53 AM, with a chief complaint of an eye injury. The triage assessment, completed on April 2, 2007, at 2:13 AM, showed that Patient 122 was hit in his right eye earlier in the evening, his eye was reddened and teary, he was unable to see out of his right eye when checking his visual acuity, and he had a large right hyphema (bleeding in the anterior chamber of the eye). The ED physician's notes showed that Patient 122 had a large right hyphema, and would be transferred to another facility due to "no ophthalmology on call at Inland Valley." Patient 122 was transferred to another facility at 3:58 AM, for a "higher level of care." A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two ophthalmologists on active staff, and one ophthalmologist in provisional status seeking active staff membership. g. Patient 124, a 17 year old female, presented to the ED on April 13, 2007, at 7:03 PM, with a chief complaint of bloody urine and vomiting. The triage assessment completed on April 13, 2007, at 7:19 PM, showed that Patient 124 had lower abdominal pain, with vomiting every 2 hours for a week. She also complained of weakness and dizziness. The ED physician's notes showed that Patient 124 was in Acute Renal (kidney) Failure,	A 185	The Governing Body also reviewed and confirmed that the physicians who elect to participate in taking call for the ED are then obligated to respond to calls from the Hospital: --Once a physician volunteers to participate in call, the on-call physician must respond to the ED at least by telephone within 30 minutes of receiving a call, unless the physician is unable to respond for an appropriate reason (i.e., due to circumstances beyond the physician's control, such as the fact that the on-call physician is in emergency surgery for another patient). --If asked, the on-call physician must come to the ED within 30 minutes and provide care to unassigned patients. --If indicated, during the telephone call, the on-call physician can provide feedback, information, and/or orders to the ED staff to act on while the on-call physician is coming to the ED. For example, when a patient must go to emergency surgery, the Hospital uses the time a surgeon is in transit to the Hospital to gather the OR team and prepare a patient for surgery so there is no delay once the surgeon arrives at the Hospital. Administration provided reminder training to all RN and Respiratory Care Professional staff on the 30 minute response requirement for physicians, how to run the chain of command, and when to complete an HPRR, as described in A 186.	06/18/07 06/29/07

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A 185	Continued From page 97 and had Anemia (low blood counts). The ED physician called the pediatrician on call, who was not available to care for Patient 124. Patient 124 was transferred to another facility for care and treatment at 2:11 AM, nearly seven hours after arriving in the ED for treatment. h. Patient 129, a 44 year old male, presented to the ED on April 8, 2007, at 11:50 PM, with a chief complaint of chest pain and shortness of breath. The ED physician's notes showed that the patient had Congestive Heart Failure, Hypertension and Cardiomegaly (enlarged heart). On April 9, 2007, at 4 AM, the physician on call for Internal Medicine was called by the ED physician to admit the patient. At 6 AM, there was no response from the on call physician, and another call was placed. At 7 AM, the on call physician called in to the ED, and agreed to admit the patient. The response time for this on call physician was three hours. The Emergency Medicine (EM) minutes for IVMC were reviewed on May 30, 2007, at 10:45 AM, and again on May 31, 2007, at 12:55 PM. There was no evidence of a discussion regarding the lack of availability of specialists on-call on weekends and evenings. In September 2006, Page two, section D of the minutes was titled, "Call panel Validation." The minutes stated, "For physicians not on suspension, the ED has calling been to confirm assigned call. The CEO indicated she is working on a plan/process for everyone, and will give information to the ED Medical Director. The CEO indicated the verification of daily assigned call will not be done through the Medical Staff Office." During an interview with the Chief Nursing	A 185	The Medical Staff members of the Governing Board drafted and circulated a letter to all Medical Staff members reminding them that they must respond at least by telephone to calls from Hospital staff about their inpatients, and when they are on call for the ED, they must respond by telephone or in person to calls from the ED within 30 minutes, and must come to the ED within 30 minutes when requested. The letter was mailed, faxed, placed in physicians' mailboxes, and posted in all physician areas at both Hospital campuses. Administration reviewed and confirmed several transfer agreements that it has with hospitals to facilitate the transfers of patients from the ED when those facilities are the best facilities available to furnish care the Hospital cannot provide. For example, the Hospital has one transfer agreement specifically with a children's hospital for pediatric transfers. Administration entered into two additional transfer agreements to facilitate transfers from the ED. ED Leadership is responsible for reviewing a random sample for the timely response to page by the ED call panel physician. Please also see description of monitoring for reason and appropriateness of transfers as described earlier in this tag and under A 456, and for additional actions to monitor physicians' response to calls under A 186. The COO and/or the PI/RM chair are responsible for reporting the analysis of the monitors to the ED Department, the PI/RM	06/21/07 06/25/07 06/25/07 07/03/07 & ongoing 07/03/07 & ongoing

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A 185	Continued From page 98 Executive (CNE) on May 30, 2007, at 11:50 AM, the CNE stated that she received complaints from the nursing staff about the physicians not being available when the nurses called them. The CNE said the complaints were becoming "slightly more" in the ED, and "noticeably more" in the ICU. The CNE stated that there was no particular day of the week, time of day, or specialty that was complained about more. She stated it seemed to be more of an "individual person problem." She declined to give names of the physicians the nursing staff complained about. During an interview with the Director of the ED on May 31, 2007, at 11:35 AM, she stated that she was aware that the ED on call schedule did not include all specialties that were offered by the facility. The ED Director stated that she was aware that patients were transferred out of the ED as a result of not having specialty call coverage, and stated that it occurred approximately twice a month to her knowledge, but she only heard about the "particularly messy patients". She stated that the ED physicians complained regularly about the lack of specialty on call coverage, and that they were supposed to be informing the administrator on call every time a patient was transferred to another facility due to no specialist available to care for the patient, then do an HPRR. The ED Director stated that this issue had been reported to administration, and administration answered, "we're discussing it". She stated that this was a "closed administration at the senior level", and that they did not share information with the management team. During an interview with the Director of Performance Improvement (PI) on May 31, 2007, at 12:10 PM, she stated that the issue of not	A 185	Committee, the MEC, and (as indicated) the Governing Body to inform those committees in regularly assessing the appropriateness of on-call coverage for the ED. ALLEGATION OF COMPLIANCE: The Hospital nevertheless respectfully disagrees that it failed to meet this standard. The citations inappropriately expand the rule when they state the facility failed to ensure that the medical staff was accountable to the Governing body for the provision of physician oncall services to 15 patients. That is not the standard established by the Medicare rules. The CoP on Emergency Services states that hospitals "must meet the emergency needs of patients in accordance with acceptable standards of practice." As noted above, the Interpretive Guidelines further clarify that "acceptable standards of practice" include "maintaining compliance with applicable Federal and State laws, regulations, and guidelines regarding hospital emergency services, as well as any standards or recommendations promoted by or established by nationally recognized professional organizations" such as the AMA, ANA, or ACEP. "Acceptable standards of practice" include the EMTALA rules. Neither the Emergency Services CoP nor EMTALA requires ED call coverage for every service a hospital offers, and the 2567 does not cite any other standards that do.	

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

Withdrawn

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

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	The following reflects the findings of the California Department of Public Health, formerly known as the Department of Health Services during the investigation of Complaint Numbers CA00115208 and CA00116136. The Southwest Healthcare System is comprised of two hospitals under the same licensure (Inland Valley Medical Center and Rancho Springs Medical Center). Representing the California Department of Public Health: Carolyn McHugh, HFEN Tina Buchanan, HFEN Bonnie Holle, HFES Morton Kligerman, M.D., MPH, Medical Consultant Based on interview and record review, the facility failed to provide adequate on-call physician coverage to meet the needs of nine of 56 patients needing emergency services at IVMC (Patients 105, 118, 119, 120, 121, 122, 124, 129 and 202), and seven of 68 patients (Patients 31, 36, 40, 203, 204, 205 and 206) needing emergency services at RSMC. Findings: On May 30, 2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated the practice of the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the Governing Body initially approved the voluntary call system on a trial basis		By submitting this plan of correction, the Hospital does not agree that the citations are correct or that it violated the rules. Please see credible allegation of compliance following each description of corrective action the Hospital has taken to address the concerns of the surveyors. Please note that this report contains citations that are similar to those contained in the CMS 2567 issued on June 13, 2007. The corrective actions implemented in response to that plan of correction were reviewed and accepted by California Department of Public Health on July 13, 2007. Nothing described elsewhere in this 2567 meets the definition of immediate jeopardy because none of the findings indicate any licensure violation that caused or is likely to cause serious injury or death to a patient. The basis for this contention is explained in the allegations of compliance listed under each of the citations. The Hospital requests an informal conference with the district administrator/district manager to contest or appeal this finding. Nothing described elsewhere in this 2567 meets the definition of immediate jeopardy because none of the findings indicate any licensure violation that caused or is likely to cause serious injury or death to a patient. The	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dennis Knox | TITLE: CEO | (X6) DATE: 4/11/08

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 Department of Public Health

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A 014	Continued From Page 1 requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.	A 014	basis for this contention is explained in the allegations of compliance listed under each of the citations. The Hospital requests an informal conference with the district administrator/district manager of the meeting to contest or appeal this finding.	
E 733	T22 DIV5 CH1 ART6-70415(a)(3) Basic Emergency Medical Service, Physician on (3) Development of a roster of specialty physicians available for consultation at all times. Based on interview and record review, the facility failed to provide adequate on-call physician coverage to meet the needs of nine of 56 patients needing emergency services at IVMC (Patients 105, 118, 119, 120, 121, 122, 124, 129 and 202), and seven of 68 patients (Patients 31, 36, 40, 203, 204, 205 and 206) needing emergency services at RSMC. Findings: On May 30, 2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated the practice of the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the Governing Body initially approved the voluntary call system on a trial basis for 90 days, and subsequently extended the trial time on two separate occasions. At this time, the on-call physician coverage remained voluntary. The meeting minutes for the Emergency Medicine Department were reviewed on May 30, 2007, at 10:50 AM. The minutes, dated September 2006, included a section titled, "Call	E 733	At the request of the California Department of Public Health, this section summarizes and clarifies the plan of correction detailed in the subsequent pages under tag E 733. The Hospital has taken the following actions to be sure the Hospital Emergency Department (ED) has developed and maintains a roster of specialty physicians available for consultation at all times: SUMMARY OF PLAN OF CORRECTION: The Hospital's Governing Body reviewed and confirmed the factors underlying the plan for staffing on-call specialist coverage for the ED to assure that there is coverage at all times by specialists, including anesthesiologists, internists/family practitioners, pediatricians, OB/gynecologists, surgeons, orthopedic surgeons, and trauma surgeons. The plan provides coverage for patients who typically require the Hospital's services, and includes backup arrangements for admitting or transferring patients with needs the Hospital cannot address. (See pages 2-4 of 35). The CEO met with the physician leaders of the ED and reviewed the plan for staffing on-call specialist coverage for the ED. (See pages 4-7 of 35). Among other things, the CEO and physician leaders identified those services the Hospital does not offer and those services (such as allergy) for which specialist coverage is best handled by the internists/family practitioners, general surgeons, and other specialists who regularly provide call coverage for the ED.	06/18/07 & 07/03/07 07/02/07 & 09/17/07

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	Continued		The CEO solicited input from the physician leaders of the ED and developed a grid to increase the efficiency of ED staff when calling the appropriate specialist(s) on call for particular patient needs, and/or when calling another hospital to arrange a patient transfer. (See pages 7-8 of 35).	07/03/07
E 733	T22 DIV5 CH1 ART6-70415(a)(3) Basic Emergency Medical Service, Physician on (3) Development of a roster of specialty physicians available for consultation at all times.	E 733	The CEO solicited input from the physician leaders of the ED and revised the ED on-call list so that all pertinent information about specialists appears on one page and more efficiently guides the ED staff in contacting the appropriate specialist for ED patients. (See page 8 of 35). The CEO and the Chair of the PI/RM Committee drafted a memorandum and circulated the memorandum with the revised on-call list and grid to ED staff to instruct them on the changes and on how to use the information efficiently so that ED staff do not waste valuable time attempting to contact specialists who are not scheduled to take call for the ED. (See page 8 of 35). The ED Director and Managers re-educated ED staff on the process for using the on-call list and grid to obtain timely and appropriate emergency care for ED patients, and on transferring ED patients when transfer is necessary. (See page 8 of 35). The CEO and COO continue negotiating a teleneurology arrangement, which is projected to be finalized during the first quarter of 2008. (See pages 8-9 of 35).	07/03/07 07/03/07 07/03/07 Ongoing, projected by 03/31/08

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	Continued		The CEO confirmed that construction of the NICU, as described on page 9 of 35, is currently scheduled for completion November 2008.	12/28/07 & 11/08
E 733	T22 DIV5 CH1 ART6-70415(a)(3) Basic Emergency Medical Service, Physician on (3) Development of a roster of specialty physicians available for consultation at all times.	E 733	The Governing Body reviewed and confirmed the Hospital's system under which physicians taking call are obligated to respond when called. (See pages 9-10 of 35).	06/18/07
			The CEO reviewed and confirmed the Hospital's process for nurses to run the chain of command if an on-call physician fails or refuses to respond to calls from the Hospital. (See pages 10-11 of 35).	06/18/07
			Each department Director and/or Manager re-educated nursing and respiratory care personnel on the requirements for on-call physicians to respond and the process for running the chain of command. (See page 11 of 35).	06/29/07
			The physician members of the Governing Body drafted and circulated a letter to the Medical Staff reminding them of their call and response obligations. (See page 11 of 35).	06/21/07
			The CEO reviewed the existing transfer agreements and entered into two additional transfer agreements to facilitate transfers of patients from the ED when necessary. (See page 11 of 35).	06/25/07
			The ED Unit Secretaries and Charge RNs complete a tracking log when they page on-call physicians to document when the on-call physicians respond to the ED pages.	07/01/07

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	Continued		MONITORING:	
			The CEO is responsible for assuring the ED has a roster of the identified specialty physicians available for consultation at all times. In collaboration with the Department Chairs, the Medical Staff Office assists the CEO with this process.	06/18/07 & ongoing
E 733	T22 DIV5 CH1 ART6-70415(a)(3) Basic Emergency Medical Service, Physician on (3) Development of a roster of specialty physicians available for consultation at all times.	E 733	The PI/RM Committee reviews the plan for ED Call Panel staffing on a quarterly basis, in light of the factors listed on pages 2-7 of 35, to analyze whether call coverage is appropriate for the majority of patients who come to the Hospital's ED and to identify, and when indicated, recommended changes to the plan.	07/31/07 & ongoing
			The ED Managers review the tracking log monthly to confirm that on-call physicians are responding timely to pages by the ED and report results to the CNO/PI Director.	07/31/07 & ongoing
			The ED Managers review 100% of transfers from the ED monthly and report results to the CNO/PI Director.	07/31/07 & ongoing
			The CNO/PI Director presents aggregate data from review of the tracking log and the transfers at least quarterly to the PI/RM Committee for analysis and action planning. The PI/RM Chairperson is responsible for reporting the results of these two monitors and trends, variances, and recommendations to the MEC and the Governing Board at least quarterly. This information is used to assist the Hospital's leadership in strategic planning that can include changes to ED Call coverage, to physician recruitment goals, and/or to the services offered.	07/31/07 & ongoing

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California Department of Public Health

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	250000507	A. BUILDING _____ B. WING _____	06/01/2007

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

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E 733	Continued From Page 2 Panel Validation", which specified, "For physicians not on suspension, the ED had been calling to confirm assigned call. The CEO indicated she is working on a plan process for everyone and will give information to ED Medical Directors. The CEO indicated the verification of daily assigned call will not be through the Medical Staff Office." The meeting minutes for the Family Practice Department were reviewed on May 30, 2007. In the minutes dated November 29, 2006, there was a report by ED Physician B for ED Physician C, that advised, "Since call is currently voluntary, written agreements are currently in progress by administration for specialists. We currently do not have a formal call panel for Neurology, ENT, Pulmonology, and Ophthalmology, causing patients to be transferred." The minutes for March 2007, were also reviewed. In the first paragraph of the executive session was the statement, "The department noted that neurosurgeons have the choice to respond or not to a consult request." On May 30, 2007, the current Medical Staff Bylaws that were revised on February 26, 2007, were reviewed. The Bylaws specified that, "Each active medical staff member shall actively participate on, and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including but not limited to emergency services and back-up functions....Provisional staff members seeking Active staff membership shall participate in emergency services and back-up functions." On May 30, 2007, the Emergency Department back-up specialty call schedules for April, May and June, 2007, were reviewed . The following specialties had no formal call panel:	E 733	--What services and facilities the Hospital offered, including the services and facilities the Hospital did not offer (e.g., the fact that the Hospital does not have a psychiatric unit, a NICU, interventional cardiology, or the specialized equipment to perform complex opthalmological procedures, such as the surgery to repair retinal detachment); --The types of emergency services that the emergency physicians can provide without the need for a specialty consult or specialty evaluation in the ED because they have the training and experience to provide them, with the assistance of internists/family practitioners, orthopedists, and surgeons who are on call for the ED 24/7, 365 days/year. Such services include, e.g., allergy, dermatology, podiatry, radiation/oncology, hematology/oncology, etc.; -- The number of physicians on staff, including the number on active staff in each specialty who have committed to provide on-call coverage for the ED; --Other demands on these physicians (practice and surgery schedules, participation in medical staff leadership activities, peer review activities, utilization review, vacations, requirements to obtain continuing medical education, etc.); --The frequency with which the Hospital's patients typically require services of certain specialists in the ED; --The provisions the Hospital has made for situations in which a physician in a particular specialty is not on call or the on-call physician is unable to respond.	

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E 733	Continued From Page 3 a. Allergy (one physician on staff); b. Dentistry (one physician on staff); c. Dermatology (one physician on staff); d. Endocrinology (three physicians on staff); e. Gastroenterology (eleven physicians on staff); f. Hematology/Oncology (seven physicians on staff); g. Infectious Diseases (two physicians on staff); h. Nephrology (three physicians on staff); i. Neurology (three physicians on staff); j. Ophthalmology (three physicians on staff); k. Oral Surgery (three physicians on staff); l. Pain Management (four physicians on staff); m. Plastic Surgery (six physicians on staff); n. Podiatry (nine physicians on staff); o. Psychiatry (one physician on staff); p. Pulmonology (four physicians on staff); q. Radiation Oncology (three physicians on staff); r. Rheumatology (one physician on staff); s. Urology (five physicians on staff); and, t. Vascular Surgery (two physicians on staff). During a review of medical records on May 30, 2007, the following was noted: a. Patient 119, a 26 year old male, presented to the ED on March 27, 2007, at 10:10 AM, with a chief complaint of multiple seizures after arriving in the recovery room at a local surgery center. Patient 119 continued to have seizures while being transported to the ED by ambulance, and on arrival in the ED. The ED physician diagnosed Patient 119 with Status Epilepticus (uncontrolled seizures). The ED physician's dictated report, dated March 27, 2007, showed that Patient 119 and his family were informed of the treatment plan, "including the potential for transfer to a tertiary care center for neurology, as we have no neurology on-call." The ED physician, "spoke to a staff neurologist, however	E 733	Such provisions include: • The ability to have a general surgeon, trauma surgeon, orthopedic surgeon, obstetrician, pediatrician, neurosurgeon, family practitioner, internist, or hospitalist admit the patient to render appropriate care, * If a transfer is necessary, having readily available to ED staff a prioritized list of other facilities that are capable of handling various conditions so the ED immediately calls appropriate facilities to seek a transfer, and * Having transfer agreements in place with a number of other facilities to streamline transfer arrangements if those facilities are the appropriate places to send the patient. Hospital Administration and Governing Body members noted that: --While California provides no guidance concerning what specialties to include in the ED on-call roster, CMS recognizes that the Hospital "has the discretion to maintain the on-call list in a manner that best meets the needs of the hospital's patients." -- CMS recognizes that a hospital is not required to have 24/7 coverage in all specialties, and that implementing such coverage in some specialties (e.g., allergy or certain subspecialties with very few physicians) would detract from the availability of the most needed specialists, such as general surgeons, orthopedists, trauma surgeons, neurosurgeons, OB/GYN specialists, and cardiologists. Administration and ED Physician Leadership	6/18/07 7/2/07 & 9/17/07

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E 733	Continued From Page 4 he was not on call, and agreed with the plan to transfer." The ED physician arranged for Patient 119 to be transferred to another facility, accompanied by a critical care transport team, for neurology care. Patient 119, who required a critical care transport team, experienced a delay in treatment while phone calls were made and arrangements completed for the transfer. A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two neurologists on active staff, and two neurologists in provisional status seeking active staff membership. b. Patient 120, a 62 year old male, presented to the ED on April 2, 2007, at 11:58 PM, with a chief complaint of blindness in the right eye. The triage assessment, completed on April 3, 2007, at 12:24 AM, showed that Patient 120 had a sudden onset of loss of vision in his right eye at 10:30 PM, after hitting his head earlier in the day. The ED physician's dictated report, dated April 3, 2007, showed that Patient 120 had signs of a retinal detachment and, "this institution does not have an ophthalmologist on call." Patient 120 was transferred to another facility for a "higher level of ophthalmological care," at 7:43 AM, nearly eight hours after arrival in the ED for treatment. A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two ophthalmologists on active staff, and one ophthalmologist in provisional status seeking active staff membership. Further review of IVMC medical records on May 30, May 31and June 1, 2007 showed: a. Patient 105, a 77 year old female, presented	E 733	reviewed and confirmed there was call coverage for the following specialties, and noted that the citation is mistaken when it says that the Hospital does not have call coverage for neurology and pulmonology, which are provided as follows: --Anesthesiology (on call 24/7, 365 days/year) --Internal Medicine/Family Practice (on call 24/7, 365 days/year) --Pediatrics (on call 24/7, 365 days/year) --OB/Gyn (on call 24/7, 365 days/year) --General Surgery (on call 24/7, 365 days/year) --Orthopedic Surgery (on call 24/7, 365 days/year) --Trauma Surgery (on call 24/7, 365 days/year) --Neurosurgery (on call 24/7 for all but 2-4 days each month) --Cardiology (on call 24/7, nearly 365 days/year withcontract negotiations in process) --Neurology (currently on call 24/7 for 7 days a month, with efforts underway to add teleneurology by the end of 2007 to provide 24/7 coverage for the rest of each month) --Pulmonology (24/7 for 356 day/year as of 9/17/07) --Vascular Surgery (covered by a specific vascular surgeon when scheduled on Trauma Surgery call panel) Administration and ED Physician Leadership reviewed the specialties not covered by the ED call panel or where there are gaps in coverage, confirmed that it would not be appropriate for some specialties to take call because they do not typically treat emergencies, and therefore identified the	7/2/07

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E 733	Continued From Page 5 to the ED on March 2, 2007, at 12:36 PM, with a chief complaint of "sent by primary doctor for possible stroke." The triage assessment, completed on March 2, 2007, at 1:05 PM, showed that Patient 105 had a headache, depression, was tired and had a droopy left eye. In the ED, a Computerized Tomography (CT) scan of the head revealed a 7 x 12 mm area of bleeding in the intraparenchymal space (inside of the brain). The ED physician's dictated report dated March 2, 2007, showed that the neurosurgeon on staff was paged, and spoken to at home, but "he does not take call within our hospital, he is out of town and is not available." The ED physician made arrangements to transfer Patient 105 to another facility for a "higher level of care." The ED physician then contacted the house supervisor, "and informed her of the transfer situation...and spoke to the hospital administrator and informed her of the situation, that the patient will be transferred for a higher level of care, as there is no neurosurgical call panel here." Patient 105 was transferred to another facility for neurosurgical services at 11:20 PM, nearly 11 hours after arriving in the ED for treatment. A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two neurosurgeons on active staff. A review of the ED on-call schedule on May 31, 2007, showed that only one neurosurgeon was taking call. b. Patient 118, a 33 year old male, presented to the ED on March 4, 2007, at 2:03 PM, with a chief complaint of an injury to the left leg. An x-ray of the left tibia and fibula showed a "closed comminuted displaced fracture of the left tib-fib" (tibia and fibula). A review of the ED physician's	E 733	appropriate practitioners who provide coverage and who are qualified to assess and provide stabilizing treatment for ED patients with emergencies: --Allergy: ED physicians on site 24/7 for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365 days/year; allergists do not usually handle emergencies --Dentistry: See Oral Surgery; the only dentist on staff practices general dentistry, and any dental emergencies are actually oral surgery issues --Dermatology: ED physicians on site 24/7 for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365 days/year (to the extent a patient may have a dermatological emergency) --Endocrinology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Gastroenterology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Hematology/Oncology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Infectious Diseases: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Nephrology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Neurology (when there is a gap in coverage): ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year, and Neurosurgeons on call 24/7 for all but 2-4 days/month	

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E 733	Continued From Page 6 notes showed that "multiple calls were made to the orthopedic physician on call, with no answer." The ED physician transferred Patient 118 to another facility for orthopedic care. Patient 118 experienced a delay in treatment while waiting for numerous phone calls to be completed and arrangements to be made for transfer. c. Patient 121, a 54 year old female, presented to the ED on April 28, 2007, with a chief complaint of vomiting blood. The ED physician's notes showed that the patient was transferred to another facility for a "higher level of care, no GI (Gastroenterology) service on call." Patient 121 was required to wait for phone calls to be completed in the decision process to transfer the patient to another facility because the facility did not have an available gastroenterologist. A review of the Medical Staff Roster on May 31, 2007, showed that the facility had six gastroenterologists on active staff d. Patient 122, a 17 year old male, presented to the ED on April 2, 2007, at 1:53 AM, with a chief complaint of an eye injury. The triage assessment, completed on April 2, 2007, at 2:13 AM, showed that Patient 122 was hit in his right eye earlier in the evening, his eye was reddened and teary, he was unable to see out of his right eye when checking his visual acuity, and he had a large right hyphema (bleeding in the anterior chamber of the eye). The ED physician's notes showed that Patient 122 had a large right hyphema, and would be transferred to another facility due to "no ophthalmology on call at Inland Valley." Patient 122 was transferred to another facility at 3:58 AM, for a "higher level of care." Patient 122 experienced a delay in treatment while waiting for the emergency department to	E 733	--Ophthalmology: ED physicians on site 24/7 for 365 days/year; the Hospital does not offer complex ophthalmological surgeries because it does not have the necessary specialized equipment --Oral Surgery: ED physicians on site 24/7 for 365 days/year --Pain Management: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Plastic Surgery: ED physicians on site 24/7 for 365 days/year, and General Surgeons on call 24/7 for 365 days/year --Podiatry: ED physicians on site 24/7 for 365 days/year, Orthopedic Surgeons on call 24/7 for 365 days/year --Psychiatry: Not a service offered by the Hospital because the Hospital does not have a psychiatric unit --Radiation/Oncology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Rheumatology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Urology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Vascular Surgery: Covered 24/7 for several days a month by a specific vascular surgeon when scheduled on the Trauma Surgery call panel In addition to the plan for coverage provided above, the Hospital CEO is negotiating with urologists on the active medical staff regarding provision of urology call coverage for the ED. Resolution is expected in the 3rd quarter 2008. Administration and ED Physician Leadership developed a grid to facilitate provision of care by on-call specialists and, when a transfer is necessary, to streamline the arrangements for transfer. Specifically, the grid guides ED staff in calling the appropriate on-call specialist for ED patients, and in calling the	By 09/30/08 07/03/07

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E 733	Continued From Page 7 determine that no ophthalmologist was available and make arrangements for transfer to another facility. A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two ophthalmologists on active staff, and one ophthalmologist in provisional status seeking active staff membership. e. Patient 124, a 17 year old female, presented to the ED on April 13, 2007, at 7:03 PM, with a chief complaint of bloody urine and vomiting. The triage assessment completed on April 13, 2007, at 7:19 PM, showed that Patient 124 had lower abdominal pain, with vomiting every 2 hours for a week. She also complained of weakness and dizziness. The ED physician's notes showed that Patient 124 was in Acute Renal (kidney) Failure, and had Anemia (low blood counts). The ED physician called the pediatrician on call, who was not available to care for Patient 124. Patient 124 was transferred to another facility for care and treatment at 2:11 AM, nearly seven hours after arriving in the ED for treatment. f. Patient 202, an elderly gentleman with left-sided weakness and pneumonia was hospitalized in ICU at IVMC during the time of survey. On May 31, 2007, at 8:15 AM, Patient 202 suffered a deterioration of his respiratory status. The nurses notes contained the timeline of events. Physician H, a neurologist, was at the bedside of Patient 202 when the nurses called Physician F, a Pulmonologist/Intensivist, also Medical Director for Respiratory Services, for assistance with an emergency intubation (placement of a breathing tube into the lungs). According to the nurses notes, Physician F was unavailable to come to the hospital. The nurses then paged Physician I to assist with an emergency intubation. Physician I is also a	E 733	hospitals capable of furnishing the specialty care that the patient needs and that the Hospital cannot provide at that time. Administration and ED Physician Leadership reviewed and revised the ED on-call list so that all pertinent information about what physicians are on call appears on one page. Administration and the Chair of the PI/RM Committee revised on-call list and circulated the grid to ED staff with a memorandum confirming use of the on-call list and of the grid. Administration clarified that ED staff must contact the appropriate specialist listed on the on-call roster when needed to assess/treat a patient with a possible emergency, rather than calling physicians who are NOT on call. Administration reviewed and clarified that ED staff should arrange for an appropriate transfer when the appropriate on-call specialist is not available, there is a gap in coverage for the ED, the patient requires services the Hospital does not provide, or the patient needs a higher level of care. ED Leadership met with ED staff to discuss the system for using the on-call list and the grid to obtain appropriate emergency care for ED patients in a timely fashion. The CEO and COO are continuing to negotiate a contract for teleneurology to be available to the ED 24/7 for all days where there is no neurology coverage. Through teleneurology, the ED will have the benefit of neurologists reading tests and ordering appropriate treatment for neurological problems that require prompt	7/3/07 7/3/07 7/3/07 7/3/07 7/3/07 3/31/08

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E 733	Continued From Page 8 Pulmonary/Critical Care specialist, although he was not listed on the on-call schedule. The nurses informed Physician I that the patient required emergency intubation, but he was unavailable to come to the hospital at that time. A code blue (patient needing resuscitation team) was called and physician J, an ED physician, responded and intubated the patient at approximately 9:05 AM, 50 minutes after the patient was identified to be in severe respiratory distress requiring mechanical ventilation (breathing machine). During an interview with the Director of the ED on May 31, 2007, at 11:35 AM, she stated that she was aware that the ED on call schedule did not include all specialties that were offered by the facility. The ED Director stated that she was aware that patients were transferred out of the ED as a result of not having specialty call coverage, and stated that it occurred approximately twice a month to her knowledge, but she only heard about the "particularly messy patients". She stated that the ED physicians complain regularly about the lack of specialty on call coverage, and that they were supposed to be informing the administrator on call every time a patient was transferred to another facility due to no specialist being available to care for the patient, then do an HPRR. The ED Director stated that this issue had been reported to administration, and administration answered, "we're discussing it". She stated that this is a "closed administration at the senior level", and that they don't share information with the management team. The Medical Director of the ED (also a member of the Board of Directors) was interviewed on May 31, 2007, at 1:20 PM. He stated that the	E 733	treatment (such as administration of TPA). Administration has initiated the process for adding a NICU, which would be available to both ED patients and hospital inpatients. Under construction projected completion 12/08 The Governing Body reviewed and confirmed that the adoption of the voluntary call system did not diminish the availability of emergency services to patients. The Governing Body reviewed the overall rate of transfers out of the ED before and after the implementation of the current call system for the ED. Most significantly, the overall rate of transfers (calculated by dividing the number of transfers by the number of emergency visits for each month) has remained essentially the same, and most of the transfers are done because the patients need services the Hospital does not currently provide (such as psychiatry, interventional cardiology, and NICU services). The Governing Body also reviewed and confirmed that the physicians who elect to participate in taking call for the ED are then obligated to respond to calls from the Hospital: --Once a physician volunteers to participate in call, the on-call physician must respond to the ED at least by telephone within 30 minutes of receiving a call, unless the physician is unable to respond for an appropriate reason (i.e., due to circumstances beyond the physician's control, such as the fact that the on-call physician is in emergency surgery for another patient). --If asked, the on-call physician must	6/18/07 6/18/07

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E 733	Continued From Page 9 voluntary call system was "inconvenient" and that often patients were transferred for the lack of an available specialist. He stated that "It's a problem" and that he had empathy for the patients. He stated the primary issue was customer satisfaction. He stated that although many specialties did not have a physician on-call, Urology was the most common specialty to have nobody who would come in to see a patient. He stated the problem with ventilated patients had improved since Physician D joined the pulmonary/intensive care team. However, he (Physician D) was only on-call one week every four weeks. He stated that the ED physicians are "working with what we have to work with." He further stated that no Quality Assurance/Performance Improvement (QAPI) activities were being done to determine the effect the voluntary call system had on patient care, transfers or time spent trying to find a consultant. The Medical Director stated that he spoke at one of the Medical Executive Committee (MEC) meetings, and he told the committee about the difficulty dealing with the voluntary call system; "but until you are in my shoes, looking into the patient's eyes, you cannot know how we (the ED physicians) feel." During a review of ED medical records at RSMC on June 1, 2007, the following was noted: a. Patient 31, an 84 year old male, presented to the ED on April 20, 2007, at 5:57 PM, with a chief complaint of a syncopal (dizzy) episode and a fall. The triage assessment, completed on April 20, 2007, at 6:06 PM, showed that Patient 31 had a hematoma (blood pocket under the skin) above the left eye and on the left forehead, and had a headache. The nurse's notes showed that the patients headache continued throughout the ED stay, and he was medicated on five different	E 733	come to the ED within 30 minutes and provide care to unassigned patients. --If indicated, during the telephone call, the on-call physician can provide feedback, information, and/or orders to the ED staff to act on while the on-call physician is coming to the ED. For example, when a patient must go to emergency surgery, the Hospital uses the time a surgeon is in transit to the Hospital to gather the OR team and prepare a patient for surgery so there is no delay once the surgeon arrives at the Hospital. Administration reviewed and confirmed the Hospital has an effective process for enforcing these requirements. The chain of command assists the nursing staff in responding to the needs of patients, and the reporting and monitoring system is the tool for enforcing the Bylaws provision as follows: --When a physician does not respond timely to a page and the nurses have to run the chain of command as necessary to meet an urgent patient care need, they are supposed to generate a Healthcare Peer Review Report (HPRR). --The information in the HPRR goes to the physician's Department Chair to address with the physician informally. --The information in the HPRR is also kept for tracking purposes and for consideration during the physician's recredentialing process. --If a physician shows a trend of slow response to pages, then the Hospital holds a	6/18/07

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E 733	Continued From Page 10 occasions for the pain. The ED physician dictated report showed that Patient 31 had a Computerized Tomography (CT) scan of his head, that showed a subdural hematoma (bleeding in the brain) on the right side. The ED physician noted that the facility neurosurgeon was not on call that day, and "he will be transferred for a higher level of care, we do not have a neurosurgeon on call at this time". Patient 31 was transferred to another facility at 9 PM, with a blood pressure of 195/66, accompanied by a critical care transport team, for a "higher level of care". A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two neurosurgeons on active staff, and only one neurosurgeon was serving on the ED backup call schedule. A review of the April 2007 Emergency Department On-Call Schedule on May 31, 2007, showed that there was a neurosurgeon scheduled to be on call on April 20, 2007. b. Patient 36, a 60 year old male, presented to the ED on April 4, 2007, at 3:47 AM, with a chief complaint of abdominal pain. The ED physician dictated report showed that the patient had a kidney stone on the right side, and needed to be seen by a urologist. The ED physician contacted a urologist on staff at the facility, who did not come in to see Patient 36. Patient 36 was transferred to another facility at 8:50 AM, for urology care. Patient 36 waited for arrangements to be made for transfer after the emergency department staff determined by phone calls that no urologist was available, experiencing a delay in treatment. Review of the Medical Staff Roster on May 31,	E 733	formal meeting with the physician to discuss the problem and corrective action, and the physician is monitored after that for a period of time to be sure there are no further delays in responding to pages. Administration provided reminder training to all RN and Respiratory Care Professional staff on the 30 minute response requirement for physicians, how to run the chain of command, and when to complete an HPRR, as described above. The Medical Staff members of the Governing Board drafted and circulated a letter to all Medical Staff members reminding them that they must respond at least by telephone to calls from Hospital staff about their inpatients, and when they are on call for the ED, they must respond by telephone or in person to calls from the ED within 30 minutes, and must come to the ED within 30 minutes when requested. The letter was mailed, faxed, placed in physicians' mailboxes, and posted in all physician areas at both Hospital campuses. Administration reviewed and confirmed several transfer agreements that it has with hospitals to facilitate the transfers of patients from the ED when those facilities are the best facilities available to furnish care the Hospital cannot provide. For example, the Hospital has one transfer agreement specifically with a children's hospital for pediatric transfers. Administration entered into two additional transfer agreements to facilitate transfers from the ED.	6/29/07 6/21/07 6/25/07 6/25/07

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E 733	Continued From Page 11 2007, showed that the facility had six urologists on active staff. A review of the ED on-call schedule on June 1, 2007, showed the urology service ED call listed as "voluntary". c. Patient 40, a 43 year old male, presented to the ED on April 23, 2007, at 10:28 AM, with a chief complaint of sore throat. The ED physician dictated report showed that Patient 40 had a peritonsillar abscess (an abscess around the tonsils), and was having difficulty swallowing. The ED physician noted that he, "discussed transferring the patient for ENT (Ear, Nose and Throat) services, as we have no ear/nose/throat specialist on call today". Patient 40 was transferred to another facility at 12 PM for a "higher level of care for ENT services". A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two ophthalmologists on active staff. A review of the ED on-call schedule on June 1, 2007, showed the ophthalmology service ED call listed as "voluntary". d. Patient 203, an elderly female, presented to the ED on May 21, 2007, by ambulance, with a complaint of abdominal pain. The patient had a Computerized Tomography (CT) scan of the abdomen, which was normal. A repeat CT with contrast (used to enhance the image) showed gastritis (inflammation of the stomach). The final diagnoses were Elevated Digoxin Level (a medication used to stimulate a failing heart) and Acute Gastritis. The patient was transferred to another facility for treatment. No documentation was present regarding the reason for transfer. Both of the transfer diagnoses were common	E 733	ED Leadership is responsible for reviewing a random sample for the timely response to page by the ED call panel physician. The COO and/or the PI/RM chair are responsible for reporting the analysis of the monitors to the ED Department, the PI/RM Committee, the MEC, and (as indicated) the Governing Body to inform those committees in regularly assessing the appropriateness of on-call coverage for the ED. ALLEGATION OF COMPLIANCE The Hospital disagrees that it violated this rule related to the requirement to develop a roster of specialty physicians and requests an informal conference with the district administrator/district manager of the meeting to contest or appeal this alleged violation. The Hospital also disagrees that there was an immediate jeopardy regarding this citation. The citations incorrectly interpret the bylaws and inappropriately expand the rule when they state, "[T]he facility failed to ensure that the medical staff was operating under current bylaws, rules and regulations that were approved by the Governing Body." Southwest Healthcare System at all times has had a roster of specialty physicians who were available to treat emergency patients. In support of this allegation, the report lists specialties that do not have a call panel, including allergy, dermatology, endocrinology, hematology/oncology, infectious disease,	7/3/07 & ongoing 7/3/07 & ongoing

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E 733	Continued From Page 12 medical conditions, usually treated by a cardiologist and a gastroenterologist. Both services were offered at this hospital, however the Gastroenterologists are on a voluntary call schedule for ED back up. patient 203 experienced a delay in treatment while waiting for arrangements for transfer to be made after the emergency department staff determined no gastroenterologist was available for consultation. e. Patient 204, an elderly female, presented to the ED on May 21, 2007. The physician's notes indicated that she was to be admitted to the telemetry unit with a diagnosis of Cerebral Vascular Accident (CVA, stroke). The nurses notes also stated "Admit to telemetry". Patient 204 was instead transferred to another facility. No documentation was present regarding why the admission was changed to a transfer. A CVA was a common neurological condition, usually treated by a neurologist. The hospital provides neurology services, but the neurology service has a voluntary call schedule for ED back up. f. Patient 205, a young man, presented to the ED on May 5, 2007, with a chief complaint of an eye injury. The ED physician noted that there was a laceration to the upper eyelid that would require the services of a plastic surgeon, a specialty service that is offered at this hospital. However, plastic surgery physicians are on a voluntary call schedule. The patient was transferred to another facility for care. g. Patient 206, a female patient, presented to the ED on May 29, 2007, via paramedics, with a chief complaint of inability to speak and right sided weakness. The ED physician's notes indicated the patient had a probable CVA. This was a common neurological condition usually handled by a neurologist, a service offered at this	E 733	nephrology, podiatry, psychiatry, radiation oncology, rheumatology, and vascular surgery. These examples do not support the finding of a violation or immediate jeopardy for the following reasons: --Many of these listed specialties would never be required to manage an emergency because the ED physicians or more general on-call specialists can handle the emergency. For example, ED physicians regularly treat and stabilize allergic reactions and do not call an allergist. --The Hospital does not offer psychiatric services--it has no psychiatric unit or beds; there is one psychiatrist on staff to provide an occasional consult for an inpatient who has psychiatric problems secondary to the medical issues. --The listing of no vascular surgery call panel indicates the surveyors failed to recognize that one of the two vascular surgeons on staff already participates regularly in the trauma call panel providing emergency coverage for the ED. California regulations provide no guidance whatsoever concerning what specialties must be provided on call. The rule does not require 24/7 emergency call coverage for all services offered by the Hospital. Related Medicare regulations and comments, which do provide some guidance about call coverage, recognize that individual physicians are not required to be on call 24/7 and that there may be gaps in coverage. The citation fails to note that the Hospital meets these emergency needs of patient at all times through the following:	

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E 733	Continued From Page 13 hospital. Patient 206 was transferred to another facility. The ED physician's notes stated, "We do not have neurology on call." During an interview with the ED Unit Secretary (US) on June 1, 2007, at 10:40 AM, the US stated that when she needed to call a specialty physician, she asked the ED physician or the patient's primary care physician (PCP) which specialist they wanted her to call. She then called that specialist and asked them if they would "consider" taking care of the patient. If the specialist declined, she asked the ED physician or the PCP who to call next, and she continued until she found a specialist that was "willing" to take care of the patient. The US stated that she was "usually" able to find somebody to come in. She stated that if they were unable to find a specialist, then the patient got transferred to another facility, but "that doesn't happen very often". During an interview with ED Physician 2 on June 1, 2007, at 11:13 AM, he stated that the voluntary call system "made the job more difficult". ED Physician 2 stated that he had been using the Internal Medicine (IM) or Family Practice (FP) physician for advice on what specialist to call. He stated that it took longer to get a specialist now that it was voluntary, and he had to make multiple calls, but he could usually get somebody to come in.The facility transfer policy was reviewed on May 30, 2007. The policy stated that, "The policy and philosophy of Southwest Healthcare System (SWHCS), emergency services and care will be provided to any individual who requests services...." The policy also stated that, "Unless extenuating circumstances are present, no patient will be transferred to another facility if SWHCS has the means to provide the care." Some conditions	E 733	--There is a qualified ED physician on duty at all times in the ED at each hospital campus; --There is a call roster for the ED so that at any given time the ED knows what specialties are covered, and when physicians are on call for the ED, they MUST respond, come to the ED when requested, and provide care to unassigned patients. --The call roster reflects coverage 24/7, nearly 365 days/year by the major specialties needed by ED patients; these include internal medicine/family practice, pediatrics, general surgery, orthopedic surgery, neurosurgery, and cardiology, among others. --The Hospital furnishes 24/7 nursing services and staffs with nurses trained to handle emergencies. Several cases are cited in the 2567 to support the allegation that the Hospital failed to meet the emergency needs of its ED patients. However, instead of showing failure to meet the emergency needs of patients, these cases demonstrate how the Hospital successfully meets the emergency needs of its patients. Citing these cases seems to send the message that no patients should EVER be transferred, when the state and federal rules clearly permit appropriate transfers and encourage them when they are necessary to assure patients receive the care they need. As further proof of compliance and lack of immediate jeopardy, the Hospital has provided additional relevant information that confirms the hospital's compliance with the regulation or misstatements in the survey report:	

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E 733	Continued From Page 14 that required transfer to another facility included, "If physician specialty is unavailable due to gaps in the on-call physician schedule..." The Emergency Medicine (EM) minutes were reviewed on May 30, 2007, at 10:45 AM, and again on May 31, 2007 at 12:55 PM. There was no evidence of a discussion regarding the lack of availability of specialists on-call on weekends and evenings. The Medical Director of the ED (also a member of the Board of Directors) was interviewed on May 31, 2007, at 1:20 PM. He stated that the voluntary call system was "inconvenient" and that often patients were transferred for the lack of an available specialist. He stated that "It's a problem" and that he had empathy for the patients. He stated the primary issue was customer satisfaction. He stated that although many specialties did not have a physician on-call, Urology was the most common specialty to have nobody who would come in to see a patient. He stated the problem with ventilated patients had improved since Physician D joined the pulmonary/intensive care team. However, Physician D was only on-call one week every four weeks. He stated that the ED physicians were "working with what we have to work with." He further stated that no Quality Assurance/Performance Improvement (QAPI) activities were being done to determine the effect the voluntary call system had on patient care, transfers or time spent trying to find a consultant. The Medical Director stated that he spoke at one of the Medical Executive Committee (MEC) meetings, and he told the committee about the difficulty dealing with the voluntary call system; "but until you are in my shoes, looking into the patient's eyes, you cannot know how we (the ED physicians) feel	E 733	Patient #36: The record indicates that the patient with a complex urologic history received an appropriate medical screening examination, and it was determined that the patient had problems with a special indwelling catheter, which had been inserted at the VA hospital. The patient had a long history of treatment at the VA hospital for urological problems. The ED physician consulted with a urologist by phone and was able to evaluate and stabilize the patient. The patient was then transferred to the VA Hospital where the patient had undergone the catheter procedure; the transfer was appropriate for continuity of care. Patient #40: The record indicates that this 40-year-old man had a peritonsillar abscess. There was no ENT physician on call at the time. The ED physician attempted to make arrangements for transfer to a hospital with an ENT on call, which was appropriate and reasonable. Patient #105: On March 2, 2007, this patient was sent to the ED by her primary physician for evaluation of possible stroke and was found to have a bleed. The ED physician was able to talk to one of the neurosurgeons on staff regarding options for the patient, but the neurosurgeon was not on call and was out of town that day. It was nevertheless helpful to the ED physician to consult with the neurosurgeon even though the patient needed to be transferred. The ED physician was able to address any emergent needs the patient had and transferred the patient in a stabilized condition to another hospital. Additionally, the hospital implemented nearly 24/7 call coverage for	

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E 733		E 733	neurosurgery by March 8, 2007, just after this case occurred. Therefore, the hospital appropriately transferred this patient, and then improved the call coverage for neurosurgery well before the survey. Patient #118: This patient was evaluated in the ED for a fracture of his left leg. While there was an orthopedic surgeon on call for the ED that day, the patient requested that the ED physician contact the patient's primary care physician about the case. The patient's primary care physician requested that the patient be transferred to the hospital where the primary care physician had privileges and where the patient could continue to be followed by his regular treating orthopedist. After the ED physician stabilized the patient's fracture, he transferred the patient as requested by the patient and the primary care physician. Patient #119: A review of the medical record of patient #119 indicates the Hospital met the patient's emergency needs as follows: --Although the patient came in at 1010 on March 27, 2007 having seizures and was diagnosed with Status Epilepticus, the Hospital provided medication so that the LAST documented seizure occurred at 1224, and the patient was alert and interacting by 1354. The transfer did not occur for 6 hours after the last seizure. --The patient was transferred in a stabilized, nonemergent condition at 1623 to a facility with neurologists available to do a complete workup and address ongoing treatment. The patient was no longer having seizures, and the ambulance transporting the patient had a critical care nurse on board	

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E 733		E 733	merely as a precaution. Patient #120: The 2567 cites patient #120 as an example of a transfer (a) necessitated because there was not an ophthalmologist on call, and (b) done nearly eight hours after the patient's arrival in the ED. An analysis of the record confirmed that neither conclusion is correct. --The patient would have been transferred even if an ophthalmologist had been available. Because the patient had a possible retinal detachment that could require a complex surgical procedure, and because the Hospital does not have the specialized equipment to do those procedures, the patient was transferred to a tertiary care facility that performs a large number of those procedures. --Additionally, the 2567 states that this patient was transferred at 0743 on April 3, 2007; the medical record documents, however, that the patient left the ED at 0336, about 3 ½ hours after arriving at the ED. Because the patient reported hitting his head, the ED physician had CT scans done of the head and orbits to confirm there were no fractures before arranging a prompt transfer to the tertiary care facility to treat the possible retinal detachment definitively. Patient #121: This patient was evaluated in the ED, where the ED staff found no evidence of GI bleeding after inserting a nasogastric tube and having an abdominal CT done. The patient was offered admission but refused and requested transfer to another hospital. This request was honored, and the patient was transferred.	

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E 733		E 733	Patient #122: This patient came to the ED needing further examination and treatment by an ophtalmologist. Because there was not an opthalmologist on call for the ED, the patient was appropriate stabilized and transferred to another hospital. Patient #124: This patient was evaluated in the ED and required inpatient admission related to acute renal failure and anemia. However, the patient required care in a pediatric ICU, which the Hospital does not have. Arrangements were made to transfer the patient to a Hospital with a Pediatric ICU that could provide the services required by the patient. Patient #203: This patient was evaluated for abdominal pain; the first CT scan came back negative, and the second CT scan indicated gastritis. This patient was transferred to another hospital because her primary physician was not on staff at the Hospital. The ED made sure the patient was not in an emergent state, and then transferred her in a stable condition to a hospital where her physician had privileges. Patient # 204: The report incorrectly reports what occurred with this patient. This patient was not transferred. She was admitted to the Hospital. After discussions concerning possible nursing home placement, the patient chose to be discharged home, and the discharge took place the day after admission. Patient #205: This patient was appropriately evaluated in the ED. The patient needed plastic surgery to repair a laceration to his eyelid. However, there were	

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E 733		E 733	no plastic surgeons on call at the time he presented. The Hospital made arrangements for an appropriate transfer to another hospital that had plastic surgery capability. Patient # 206: An ambulance brought this patient to the ED with possible CVA. The patient was appropriately evaluated, and it was determined that the patient needed to be admitted. Because the patient's primary care physician had privileges at another hospital, the patient requested transfer to that hospital. The patient was transferred after being stabilized. For these reasons, the Hospital submits that the Hospital was and is in compliance with this rule; that this citation should be removed; and that the entire 2567 should be withdrawn.	

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	Continued		At the request of the California Department of Public Health, this section summarizes and clarifies the plan of correction detailed in the subsequent pages under tag E 1166. The Hospital has taken the following actions to be sure the Hospital Intensive Care Unit (ICU) has a system for assuring physician coverage for the ICU:	
E1166	T22 DIV5 CH1 ART6-70495(a)(2) Intensive Care Service Staff (2) Development of a system for assuring physician coverage.	E1166	SUMMARY OF PLAN OF CORRECTION: The Governing Body and MEC reviewed and confirmed that the Medical Staff Bylaws require physicians who admit their patients to the Hospital to be available to provide care for their patients in a timely manner or to arrange for an alternate practitioner who has equivalent clinical privileges at the Hospital, and that physicians must respond to calls from the Hospital within 30 minutes. (See pages 16-17 of 35).	06/18/07
			The physician members of the Governing Body drafted and circulated a letter to the Medical Staff reminding them of their call and response obligations. (See page 17 of 35).	06/21/07
			The CEO reviewed and confirmed the process for nurses to obtain timely assistance from physicians for ICU patients with emergency needs. This process includes calling the attending physician; an appropriate consulting physician already caring for the patient; the ED physician; if available, a specialist on-call for the ED; and, if necessary, the appropriate supervisor to run the chain of command. (See pages 17-18 of 35).	06/18/07
			The CEO reviewed and confirmed the Hospital's process for nurses to run the chain of command if an on-call physician fails or refuses to respond to calls from the Hospital. (See pages 18-19 of 35).	06/18/07
			The CNO confirmed that training on running the chain of command is included in each annual competency update that all staff members complete, and then re-educated nursing and respiratory care personnel on the process for running the chain of command. (See page 19 of 35).	06/29/07

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	Continued		The Department of Medicine met and discussed methods for making it more efficient for nurses to reach physicians with calls about inpatients. (See page 20 of 35).	08/01/07
E1166	T22 DIV5 CH1 ART6-70495(a)(2) Intensive Care Service Staff (2) Development of a system for assuring physician coverage.	E1166	The HPRR system is the primary method for nurses to identify physicians who fail to respond timely. The Risk Manager forwards an HPRR about a physician to the physician's Department Chair, who addresses the issue with the physician. If the problem continues, a physician's Department Chair may require the physician to appear and may impose a monitoring plan if indicated. (See pages 19-20 of 35).	06/29/07
			The Department of Medicine directed nurses to document all calls for consultation on a log, which allows Administration and physician leadership to see whether the physicians asked for consultation are responding timely. Trends and variances on the log will be reported to the Medicine Committee and the MEC at their regular meetings in 2008.	12/01/07
			The Chair of the Department of Medicine is responsible for notifying all members of the Department about how to make it easier for the Hospital nursing staff to reach them when calling about inpatients under their care. The physician roster is located on the Hospital's intranet; computers are located in every unit for staff access. Physicians are responsible for notifying the Medical Staff Office (MSO) of any changes in their contact information. The MSO and the I/S Dept are responsible for assuring the intranet phone list that ICU nurses use to contact physicians is accurate with the physician contact information. The Hospital staff is to use the physician roster from the Hospital intranet as the most accurate list of contact information. (See page 20 of 35).	08/31/07
			The Department Directors re-educated nursing staff, and particularly ICU nursing staff, on the process for calling codes timely when a patient becomes emergent. (See page 20 of 35).	08/30/07

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	Continued		MONITORING:	
E1166	T22 DIV5 CH1 ART6-70495(a)(2) Intensive Care Service Staff (2) Development of a system for assuring physician coverage.	E1166	The Risk Manager monitors 100% of Healthcare Peer Review Reports (HPRRs) generated by nursing staff when a physician does not respond timely to a page and nurses have to run the chain of command. The ICU Staff meetings also include the opportunity for staff to identify and discuss these issues and concerns.	06/29/07 & ongoing
			The Risk Manager forwards information in an HPRR about a physician to the physician's Department Chair to address with the physician informally. (See above and page 19 of 35).	06/29/07 & ongoing
			On a quarterly basis, the Risk Manager also reports trends and variances to the PI/RM Committee, which reports as appropriate to the MEC and Governing Body.	06/29/07 & ongoing
			If a trend has been identified, the Medical Department Chairperson meets formally with a physician who has not been responding timely to pages and discusses a plan of correction. The minutes from that meeting are recorded and kept on file in the Medical Staff Office. The letter sent to the physician regarding the outcome of the meeting is placed in the physician's credential file. The Medical Department Chairperson monitors physicians under corrective action to determine whether they are responding timely to pages. If the problem continues, the issue may be referred to the MEC for corrective action as per the Medical Staff Bylaws.	07/31/07 & Ongoing

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E 733	Continued From Page 15	E 733	DETAILED PLAN OF CORRECTION:	
E1166	T22 DIV5 CH1 ART6-70495(a)(2) Intensive Care Service Staff (2) Development of a system for assuring physician coverage. Based on staff interviews and facility and patient record reviews, the facility failed to have an effective system for assuring physician coverage in the 2 Intensive Care Units for three patients of 62 reviewed at Inland Valley Medical Center and for one patient of 70 reviewed at RanchoSprings Medical Center. Findings: The medical record for Patient 135 was reviewed on May 30, 2007. Patient 135, a 66 year old male, was admitted to the Intensive Care Unit (ICU) on May 29, 2007, after an emergency tracheostomy (a tube into the trachea for breathing) was performed in the ED. On the "I.C.U./P.C.U. Flow Sheet", dated May 29, 2007, at 9:30 PM, the nurse documented that Patient 135 became agitated and was fighting the ventilator (breathing machine). The nurse also documented that the patient's attending physician and the pulmonologist were paged for assistance and there was no return call from either physician. During an interview with ICU RN 1 on May 30, 2007, at 9:50 AM, she stated that the pulmonologists took call for their own patients during the week, and the on-call pulmonologist covered on the weekends. When she was asked what they did when there was no pulmonologist	E1166	This regulation focuses on the requirement for assuring physician coverage for intensive care patients and this coverage was provided. The Bylaws and Rules and Regulations state clearly that physicians who admit patients to the hospital are responsible for responding promptly to calls about their patients or arranging for coverage when they are unavailable. With respect to the ED, although physicians have discretion about volunteering to participate on the ED call list, once they agree to take call for the ED, they must respond and come in when requested. The Hospital Governing Body and MEC leadership reviewed and confirmed that physicians who admit their patients to the Hospital must be available to provide care for their patients in a timely manner or arrange for an alternate practitioner who has equivalent clinical privileges at the Hospital. The Hospital Governing Body and MEC leadership reviewed and confirmed that participation on the call panel for the ED is not mandatory at this time, but that when a physician agrees to participate on the call panel and is on call for the ED, the physician MUST respond to the Hospital timely when called, MUST come to the Hospital timely to render care when requested, and MUST see all unassigned patients as requested. The Hospital Governing Body and MEC reviewed and confirmed the Medical Staff Bylaws provisions regarding the timeframe for responding to calls from the Hospital regarding the emergency needs of patients (both inpatients and ED patients):	06/18/07 06/18/07 06/18/07

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E1166	Continued From Page 16 on call due to the "voluntary" call system, she stated that they called the ED to see if there was somebody on call, and if not, they called all of the pulmonologists on staff until they found one that was available to help them. During an interview with the Chief Nursing Executive (CNE) on May 30, 2007, at 11:50 AM, the CNE stated that she received complaints from the nursing staff about the physicians not being available when the nurses called them. The CNE said the complaints were becoming "slightly more" in the ED, and "noticeably more" in the ICU. The CNE stated that there was no particular day of the week, time of day, or specialty that was complained about more. She stated it seemed to be more of an "individual person problem." The CNE declined to give names of the physicians the nursing staff complained about. Further review of the Medical Staff Bylaws (revised 5/22/06) on May 30, 2007, at 3:15 PM. showed that: a. Section 3.7; "Each member of the medical staff shall retain responsibility, within his or her area of professional competence, for the continuous care and supervision of each patient in the hospital for whom he or she is providing services, or arrange for a suitable alternative to assure such care and supervision." b. Section 4.2.3; "Each active Medical Staff Member shall actively participate on and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including, but not limited to emergency services and back-up functions ... c. Section 10.5.3; "A supervisory (departmental)	E1166	--Physicians with admitted patients must respond timely (within 30 minutes) or arrange for another comparable physician to take call and respond timely, AND --Physicians on call for the ED must respond by phone or in person within 30 minutes, and must come to the Hospital within 30 minutes to render care when asked to do so. When the on-call physician has responded first by telephone, he/she can give direction/orders for testing or interventions (as appropriate) while the physician is traveling to the Hospital. The Medical Staff members of the Governing Board drafted and circulated a letter to all Medical Staff members reminding them that they must respond at least by telephone to calls from Hospital staff about their inpatients, and when they are on call for the ED, they must respond by telephone or in person to calls from the ED within 30 minutes, and must come to the ED within 30 minutes when requested. The letter was mailed, faxed, placed in physicians' mailboxes, and posted in all physician areas at both Hospital campuses. Administration reviewed and confirmed the Hospital has an effective process for obtaining timely assistance from physicians for inpatients with emergency needs: --As has long been the standard of practice, attending physicians direct the care of their patients and are responsible for obtaining consults by specialists, as they deem necessary, and for arranging coverage for themselves when they are not available. If an inpatient has an emergency, the nursing staff first calls the attending physician or the physician covering for the attending.	6/21/07 6/18/07

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E1166	Continued From Page 17 committee shall conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department." d. Section 10.8.5; The duties of department chairs include, "Generally monitor the quality and appropriateness of patient care and professional performance provided by members with clinical privileges in the department ...and oversee the effective conduct of patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee," and also, "enforce Medical Staff Bylaws, Rules and Regulations and policies within the department ..." and, "provide for continuous assessment and improvement of the quality of care and services provided." The Performance Improvement Committee shall, "establish systems to identify potential problems in patient care and general areas of potential risk in clinical aspects of patient care and safety." Further review of ICU medical records on May 30, May 31 and June 1, 2007, at IVMC, showed the following: a. Patient 201, a 76-year-old male was admitted to the ICU on May 24, 2007, with a preliminary diagnosis of Epidural Abscess (collection of pus near the spinal cord). A neurology consultation, dated May 24, 2007, was handwritten in the physician's progress notes. A transcribed, dictated and very detailed neurology consultation was in the medical record, also dated May 24, 2007. The transcribed consultation note was	E1166	--Other physicians already consulting on the patient's treatment team are likewise obligated to respond if called and to provide coverage for themselves. --As a backup in an emergency, there is an ED physician in-house at each hospital, 24/7, 365 days a year. --As further backup, the nursing staff may contact the appropriate physician on the on-call panel for the ED if the ED has call coverage specified, because as the 2567 notes, section 2.2.4 of the Medical Staff Rules states that assisting with inpatient emergencies is a requirement for any physician while on call for the ED. --Because there may be occasions when there is not on-call coverage for the ED in the desired specialty, there is a need for a specialty consultant to address an emergency, and the attending physician has not found a consultant, the nursing staff can run the chain of command to get medical staff assistance with finding a consultant. --As a final and rare option, the Hospital may arrange to transfer the patient to another facility that can address the patient's problem. Administration reviewed and confirmed the Hospital has an effective process for enforcing these requirements. The chain of command assists the nursing staff in responding to the needs of patients, and the reporting and monitoring system is the tool for enforcing the Bylaws provision as follows:	06/18/07

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E1166	Continued From Page 18 identified as being performed by Physician A. At the end of the dictated consultation, Physician A noted that he would be going out of town, and had notified the admitting physician. b. Patient 202, an elderly gentleman with left-sided weakness and pneumonia was hospitalized in ICU at IVMC during the time of survey. On May 31, 2007, at 8:15 AM, Patient 202 suffered a deterioration of his respiratory status. The nurses notes contained the timeline of events. Physician H, a neurologist, was at the bedside of Patient 202 when the nurses called Physician F, a Pulmonologist/Intensivist, also Medical Director for Respiratory Services, for assistance with an emergency intubation (placement of a breathing tube into the lungs). According to the nurses notes, Physician F was unavailable to come to the hospital. The nurses then paged Physician I to assist with an emergency intubation. Physician I is also a Pulmonary/Critical Care specialist, although he was not listed on the on-call schedule. The nurses informed Physician I that the patient required emergency intubation, but he was unavailable to come to the hospital at that time. A code blue (patient needing resuscitation team) was called and physician J, an ED physician, responded and intubated the patient at approximately 9:05 AM, 50 minutes after the patient was identified to be in severe respiratory distress requiring mechanical ventilation (breathing machine). During an interview with the Director of ICU on May 31, 2007, at 10:20 AM, she stated that she got feedback, from the nurses, for all of the problems that arose in the ICU. According to the Director, the ICU nurses were having a great deal of difficulty getting a pulmonologist to assist with ventilator management up until	E1166	--When a physician does not respond timely to a page and the nurses have to run the chain of command as necessary to meet an urgent patient care need, they are supposed to generate a Healthcare Peer Review Report (HPRR). --The information in the HPRR goes to the physician's Department Chair to address with the physician informally. --The information in the HPRR is also kept for tracking purposes and for consideration during the physician's recredentialing process. --If a physician shows a trend of slow response to pages, then the Hospital holds a formal meeting with the physician to discuss the problem and corrective action, and the physician is monitored after that for a period of time to be sure there are no further delays in responding to pages. Department Managers/Directors reviewed with nursing staff members and Respiratory Care Professionals the process for running the chain of command and generating an HPRR when a physician does not respond timely to an emergency. Administration confirmed that training on the chain of command is also included in each annual competency update that all staff members complete. The Risk Management Department is responsible for monitoring HPRRs to determine whether any physician shows a trend of delay in response to calls from the Hospital. Risk Management reports to the .	06/29/07 06/29/07 06/29/07 & ongoing

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E1166	Continued From Page 19 approximately two months ago. The Director stated with the addition of a new pulmonologist, the problem had improved. She stated she received approximately two calls per month from the ICU nursing staff related to this problem. She stated that when the ICU staff needed to know who was on call for a specialty, they usually knew by "word of mouth." If not, they called the ED for information. If the ED could not help, they called the offices for that particular specialty and inquired. If the offices didn't know, they went "down the list" and called all of the physicians in that specialty to see if they could get assistance. If they were still unable to get a specialist, they called the ICU Medical Director. The ICU Director stated that when the nursing staff had a delay in getting a response from a physician, they were supposed to write an HPRR (Healthcare Peer Review Report), that was reviewed and investigated by the clinical lead, and forwarded to the Performance Improvement Department. The ICU staff meeting minutes, dated April 19, 2007, were reviewed on May 31, 2007, at 10:50 AM. Under Department Issues, there was a discussion regarding "nurse apathy". The first causative factor of nurse apathy was listed as "MD's do not seem to have accountability, do not answer pages, pass the buck, change phone numbers constantly". During an interview with ICU RN 2 on May 31, 2007, at 11:05 AM, ICU RN 2 stated that she remembered the April 19 staff meeting when the physician accountability was discussed. ICU RN 2 stated that if they need a specialist, they usually "just know who to call". If they did not know, ICU RN 2 stated, "we sometimes have to call all of the doctors on the list for that specialty". She stated that the problem had not	E1166	PI/RM Committee, which reports as appropriate to the MEC and Governing Body The Department of Medicine met and discussed methods for making it more efficient for nursing staff to reach the physicians with calls about inpatients. The Chair of the Department of Medicine is responsible for notifying all members of the Department about how to make it easier for the Hospital nursing staff to reach them when calling about inpatients under their care. The CNE is responsible for updating the intranet phone list that nurses use to contact physicians so that the list reflects the changes the physicians are making to enable nursing staff to reach them more quickly and easily. The CNE provided reminder education to nursing staff, and particularly to ICU nursing staff, about calling codes promptly what a patient becomes emergent. ALLEGATION OF COMPLIANCE The Hospital disagrees that it violated this rule related to assuring physician coverage for intensive care services and that this citation constitutes immediate jeopardy. The Hospital requests an informal conference with the district administrator/district manager of the meeting to contest or appeal this alleged violation as well as the finding of immediate jeopardy related to this citation. As described above, the Hospital has a process whereby the attending physicians or their alternates are responsible for responding to the needs of their inpatients, including patients they have admitted to the intensive	08/01/07 08/31/07 09/15/07 08/30/07

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E1166	Continued From Page 20 improved yet. During an interview with ICU RN 3 on May 31, 2007, at 11:15 AM, ICU RN 3 stated that she remembered the April 19 staff meeting where the physician accountability was discussed. ICU RN 3 stated that the problem was worse for the night shift, and on the weekends. She stated that the nurses got tired and frustrated, and "we just want to take care of our patients, and the doctors don't care". ICU RN 3 stated that she had completed HPRR's regarding her inability to reach the physicians. The Director of Respiratory Services was interviewed on May 31, 2007 at 3:25 PM. He stated that in the event a patient on a ventilator needed a change in the machine settings, the pulmonologist on call would be contacted. If there was no pulmonologist on call, or if there was no response to a page, the respiratory therapist would call their Medical Director, Physician F. Physician F is board certified in Pulmonology and in Critical Care. If he was not available, then the "chain of command" was initiated. During a review of ICU medical records at Rancho Springs Medical Center, on June 1, 2007, the following was noted: Patient 44, a 91 year old male, was admitted to the ICU on May 31, 2007, on a ventilator (breathing machine). On June 1, 2007, at 6 AM, the ICU nurse paged Pulmonologist #1, who had done the initial pulmonary consult for ventilator management, to report blood gas results (to show how well the ventilator is assisting the lungs). There was no response, so the ICU nurse repaged Pulmonologist #1 at 6:20 AM. At 6:30 AM, Pulmonologist #1 called back and said	E1166	care unit. In addition, the Hospital has a roster of pulmonologists and internists with ventilator management privileges who are available to attend emergencies related to intensive care unit patients. Also, if a intensive care unit patient has an emergency requiring immediate physician intervention, the ED physicians respond to attend those emergencies. Through this system, the Hospital assures physician coverage. As further proof of compliance and absence of immediate jeopardy, the Hospital has provided additional relevant information that confirms the hospital's compliance with the regulation or misstatements in the survey report: Patient #135: The medical record for this patient documents that the patient came through the ED on May 29, 2007, was admitted to an attending internist, was taken to surgery for an emergency tracheostomy, and then was admitted to the ICU at 1510 that same day. --The consulting pulmonologist was present in the operating room and wrote the initial ICU orders. --The record further reflects that the anesthesiologist and pulmonologist remained in the ICU for a period of time after the patient's admission to assist with stabilizing him. --At 2100, the medical record documents that the patient was becoming restless.	

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E1166	Continued From Page 21 he was not on call, but Pulmonologist #2 was. At 6:35 AM, the ICU nurse paged Pulmonologist #2. At 6:45 AM, there was no response from Pulmonologist #2, so the nurse paged again. At 6:45 AM, there was still no response from Pulmonologist #2, so the ICU nurse paged the house supervisor for assistance. At 6:50 AM, Pulmonologist #2 returned his page to the ICU nurse. During an interview with ICU RN 4 on June 1, 2007, at 11:50 AM, the nurse stated that the pulmonology service had been a problem when they were trying to get somebody to manage the patient on a ventilator, but their biggest problem was with neurology. She stated that the neurologists did not have to be on call, and MD 3 told them that he did not have to take call, so if he did not want to come in, he did not have to. ICU RN 4 stated that the ICU nurses made multiple phone calls, and spent hours of their days on the telephone trying to get in touch with doctors. Physician B, a neurologist who provided services at both hospitals, was interviewed on June 1, 2007 at 1:55 PM, by telephone. He stated that there were four neurologists on staff, and that they went to a voluntary call schedule because the call was causing "burn out" among the physicians. Physician B stated the ED physicians were "pathological dumpers" who didn't want to work-up the patients in the ED. He emphasized that the hospital was not supporting them. He also stated that the administration had arranged call coverage with a new contracted neurologist, but that she was unavailable to come to the facility when she was supposed to be on call, stating that she was not on call, or in Los Angeles. Physician B recommended the survey team review the chart of Patient 201.	E1166	--At 2130, the nurses paged the attending physician and the pulmonologist because the patient started bucking the ventilator and the nurses needed orders for medication to calm the patient. --At 2205, the nurses spoke with the surgeon on the case and obtained the necessary medication orders. There was no documentation indicating that the nurses paged the attending physician or pulmonologist again (which they obviously did not need to do). At this point, there was no need to document if those physicians responded after the conversation with the surgeon and no need to run the chain of command, which would have triggered the HPRR. --The medical record also does not indicate the patient was having an emergency; vital signs were stable and the patient was described only as "restless" when medicated with Ativan 5 minutes later. Hospital staff confirmed that if the nurses required emergency help, they would have called other members of the healthcare team, run the chain of command, and if necessary, also been able to call one of the ED physicians, who are in house 24/7, 365 days/year, to provide assistance. Patient #201: This patient was thoroughly evaluated by a consulting neurologist on 5/24, and the neurologist followed up concerning the status of the patient on 5/25. The neurologist timely dictated his consultation report and notified the patient's attending physician that he would be out of town starting on 5/25. The patient's chart in fact reflects that the consulting neurologist had	

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E1166	Continued From Page 22 Reportedly, Patient 201 was an inpatient in the ICU at IVMC. The neurologist involved in the case told the admitting physician that he would be out of town. When a neurologist was urgently needed, the contracted physician was contacted, but was unable or unwilling to come to the facility to provide consultative services for Patient 201. During an interview with ICU RN 5 on June 1, 2007, at 2:43 PM, she stated that she wrote a verbal order for a neurology consult that morning for MD 4 to do. She stated she called MD 4, and was told that MD 5 was on call for neurology, so to call that physician instead. ICU RN 5 called MD 5, and was told that MD 3 was on call for neurology, so call that physician instead. ICU RN 5 stated that if she needed to know who was on call for a specialty, she called the offices and asks if they knew. When she was asked who was on call for neurology that day (June 1, 2007), she answered, "I guess it's MD 3". ICU RN 5 stated that she did not have a call list, but she could call the ED to see who was on call. When she was asked if she was aware that there was nobody on call for neurology for the ED, she stated, "no". In the ICU on June 1, 2007, at 2:52 PM, in the presence of four ICU nurses and three ICU managers, a general question was asked of them, how much time do you spend making calls to try to find physicians? They all answered, "a lot". Physician G, an Internal Medicine doctor serving both hospitals, was interviewed on June 1, 2007 at 3:25 PM at RSMC. He stated that there had been a "couple of instances" when he had a patient who needed a Neurology consult and was unable to obtain one. He also said that he generally called Physician F when he needed a	E1166	appropriately notified the admitting physician that he would be out of town and identified other neurologists who would be available to see the patient if necessary. The patient was followed by one of the back-up neurologists on 5/26, although the patient was not having a neurological crisis of any kind. Patient #202: As required by California regulations, the ED physician was available and responded to the patient's needs when a consulting specialist physician at the patient's bedside was not able to intubate the patient and consulting pulmonologists were not present in the Hospital to respond to the patient's emergency needs. Patient #44: This record indicates that the nurse was calling the consulting pulmonologist to report the results of the patient's morning labwork and the fact that the patient was doing well on the ventilator. The consulting pulmonologist responded to the call timely within 30 minutes and asked the nurse to report the results to another pulmonologist who was covering for him/her that day. The second pulmonologist responded to the page timely within 20 minutes. When the on-call pulmonologist was reached, the physician determined that the patient was stable and gave no new orders. The cited examples do not support a finding of noncompliance with this regulation or immediate jeopardy. For these reasons, the Hospital requests that this citation be removed.	

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E1166	Continued From Page 23 pulmonology/critical care consult, bypassing the on-call schedule, because he got a better response. He added that "In general, it is not easy to get consultations at this hospital." He also stated that there was poor communication between doctors and administration.	E1166		
E1912	T22 DIV5 CH1 ART7-70703(f) Organized Medical Staff (f) The medical staff shall provide for availability of staff physician for emergencies among the in-hospital population in the event that the attending physician or his alternate is not available.	E1912	At the request of the California Department of Public Health, this section summarizes and clarifies the plan of correction detailed in the subsequent pages under tag E 1912. The Hospital has taken the following actions to be sure that a staff physician is available in the event the attending physician or his alternate is not available: SUMMARY OF PLAN OF CORRECTION: The CEO reviewed and confirmed the process for obtaining emergency assistance from a physician for an inpatient with emergency needs if that patient's attending physician or alternate is not available. This process includes calling an appropriate consulting physician already caring for the patient, if there is one; the ED physician; a specialist on-call for the ED; and, if necessary, the appropriate supervisor to run the chain of command. (See pages 24-26 of 35). The HR Director confirmed that training on running the chain of command is included in each annual competency update that all staff members complete. Department Directors or Managers re-educated nursing and respiratory care personnel on the process for running the chain of command if needed to address an inpatient emergency. (See pages 26-27 of 35). The Department Directors re-educated nursing staff on the process for calling codes timely when an inpatient becomes emergent. (See page 27 of 35).	06/18/07 06/29/07 08/30/07

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E1912	T22 DIV5 CH1 ART7-70703(f) Organized Medical Staff (f) The medical staff shall provide for availability of staff physician for emergencies among the in-hospital population in the event that the attending physician or his alternate is not available.	E1912	The Department of Medicine met and discussed methods for making it more efficient for nursing staff to reach the physicians with calls about inpatients. (See page 27 of 35). The HPRR system is the primary method for nurses to identify physicians who fail to respond timely. The Risk Manager forwards an HPRR about a physician to the physician's Department Chair, who addresses the issue with the physician. If the problem continues, a physician's Department Chair may require the physician to appear and may impose a monitoring plan if indicated. (See pages 26-27 of 35). The Department of Medicine directed nurses to document all calls for consultation on a log, which allows Administration and physician leadership to see whether the physicians asked for consultation are responding timely. Trends and variances on the log will be reported to the Medicine Committee and the MEC at their regular meetings in 2008. The Chair of the Department of Medicine is responsible for notifying all members of the Department about how to make it easier for the Hospital nursing staff to reach them when calling about inpatients under their care. The physician roster is located on the Hospital's intranet; computers are located in every unit for staff access. Physicians are responsible for notifying the Medical Staff Office (MSO) of any changes in their contact information. The MSO and the I/S Dept are responsible for assuring the intranet phone list that ICU nurses use to contact physicians is accurate with the physician contact information. The Hospital staff is to use the physician roster from the Hospital intranet as the most accurate list of contact information. (See page 27 of 35).	08/01/07 06/29/07 & ongoing 12/01/07 08/31/07

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	Continued		The Code Blue Committee recommended and the CEO and Chief of Staff have approved the implementation of a Rapid Response Team (RRT). RRTs provide support to the bedside nurse and are focused on improving patient outcomes through early recognition and intervention for signs and symptoms of destabilization that could lead to cardiopulmonary arrest.	09/11/07
E1912	T22 DIV5 CH1 ART7-70703(f) Organized Medical Staff (f) The medical staff shall provide for availability of staff physician for emergencies among the in-hospital population in the event that the attending physician or his alternate is not available.	E1912	The MEC approved the associated policies and procedures for implementing the RRT. The Education Department provided classes for the RRT members in November and December 2007 concerning the policies and procedures for the RRT program. Refresher training will be ongoing. The CNO directed the RRT Program to be piloted first at the Rancho Springs campus beginning mid-January 2008, and expanded to the Inland Valley campus following the pilot period. MONITORING: The Code Blue Committee, which is a designated subcommittee of the Department of Emergency Medicine, meets quarterly and reviews all codes in the Hospital. The Code Blue Committee analyzes the review information to address any problems or concerns that are identified, including delays in calling a Code or delays in response by physicians and staff members. There has not been any problem identified regarding the Emergency Department physician response to a Code. The Code Blue Committee is also responsible for reviewing all activations of the RRT. The Committee will analyze the review information to addresses any opportunities for improvement including delays in team activation or physician response.	12/13/07 11/01/07 -12/31/07 12/13/07 & ongoing Ongoing 01/15/08 & ongoing

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E1166	Continued From Page 23 pulmonology/critical care consult, bypassing the on-call schedule, because he got a better response. He added that "in general, it is not easy to get consultations at this hospital." He also stated that there was poor communication between doctors and administration.	E1166		
E1912	T22 DIV5 CH1 ART7-70703(f) Organized Medical Staff (f) The medical staff shall provide for availability of staff physician for emergencies among the in-hospital population in the event that the attending physician or his alternate is not available. This RULE: is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the medical staff enforced their bylaws/rules and regulations in regard to physician on-call coverage by specialists with active and provisional privileges at the facility, for 3 of 62 patients at IVMC (Patient 135, 201, and 202) and one of 70 patients at RSMC (Patient 44). Findings at IVMC: On May 30, 2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated the practice for the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the Governing Body initially approved the voluntary call system on a trial basis for 90 days, and subsequently extended the trial time on two	E1912	DETAILED PLAN OF CORRECTION: This regulation focuses on the requirement for assuring physician coverage for emergencies for inpatients in the event the attending physician is not available. The Hospital Governing Body and MEC leadership reviewed and confirmed that participation on the call panel for the ED is not mandatory at this time, but that when a physician agrees to participate on the call panel and is on call for the ED, the physician MUST respond to the Hospital timely when called, MUST come to the Hospital timely to render care when requested, and MUST see all unassigned patients as requested. Administration reviewed and confirmed the Hospital has an effective process for obtaining timely assistance from physicians for inpatients with emergency needs: --As has long been the standard of practice, attending physicians direct the care of their patients and are responsible for obtaining consults by specialists, as they deem necessary, and for arranging coverage for themselves when they are not available. If an inpatient has an emergency, the nursing staff first calls the attending physician or the physician covering for the attending.	06/18/07 06/18/07

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E1912	Continued From Page 24 separate occasions. The current on-call physician coverage for the facility was voluntary. The meeting minutes for the Family Practice Department were reviewed on May 30, 2007. In the minutes dated November 29, 2006, there was a report by Emergency Department (ED) Physician B for ED Physician C, that advised, "Since call is currently voluntary, written agreements are currently in progress by administration for specialists. We currently do not have a formal call panel for Neurology, ENT, Pulmonology, and Ophthalmology, causing patients to be transferred. The minutes for March 2007, were also reviewed. In the first paragraph of the executive session was the statement, "The department noted that neurosurgeons have the choice to respond or not to a consult request." On May 30, 2007, the Medical Staff Bylaws, that were revised on February 22, 2007, were reviewed. The Bylaws specified, "Each active medical staff member shall...Actively participate on, and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including but not limited to emergency services and back-up functions....Provisional staff members seeking Active staff membership shall participate in emergency services and back-up functions." On May 30, 2007, a review of the current Medical Staff Rules and Regulations, that were revised May 22, 2006, showed that: a. Section 1.3.2; "Each practitioner must be available to provide professional care for his/her patients in a timely manner (30 minutes) or arrange for an alternate practitioner who has equivalent clinical privileges at the hospital."	E1912	--Other physicians already consulting on the patient's treatment team are likewise obligated to respond if called and to provide coverage for themselves. --As a backup in an emergency, there is an ED physician in-house at each hospital, 24/7, 365 days a year. --As further backup, the nursing staff may contact the appropriate physician on the on-call panel for the ED if the ED has call coverage specified, because as the 2567 notes, section 2.2.4 of the Medical Staff Rules states that assisting with inpatient emergencies is a requirement for any physician while on call for the ED. --Because there may be occasions when there is not on-call coverage for the ED in the desired specialty, there is a need for a specialty consultant to address an emergency, and the attending physician has not found a consultant, the nursing staff can run the chain of command to get medical staff assistance with finding a consultant. --As a final and rare option, the Hospital may arrange to transfer the patient to another facility that can address the patient's problem. Administration reviewed and confirmed the Hospital has an effective process for enforcing these requirements. The chain of command assists the nursing staff in responding to the needs of patients, and the reporting and monitoring system is the tool for enforcing the Bylaws provision as follows:	6/29/07

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E1912	Continued From Page 25 b. Section 2.1.1; "A call panel has been established for referring patients who need hospital care to qualified medical staff members. Service on the call panel is not a privilege, but is an obligation of staff membership." c. Section 2.2.1; "Practitioners on call must respond promptly when requested to see a patient. Practitioners, including specialty consultants, must respond initially by phone or in person within approximately 30 minutes of the time the request to respond is made." d. Section 2.2.3; "When scheduled on call, each practitioner shall accept the care of all patients who are appropriately referred..." e. Section 2.2.4; "The on call specialist must also be available for inpatients. If no other specialist in that specialty is willing or able to provide care for a particular inpatient, the on call specialist has the obligation to see that patient to treat, stabilize or appropriately transfer the patient in a timely manner." f. Section 2.2.7; "A patient will be admitted in the name of the call panel practitioner. The call panel practitioner must be notified about each admission to his service prior to the patient leaving the Emergency Department, and following a discussion with the Emergency Department physician." The medical record for Patient 135 was reviewed on May 30, 2007. Patient 135, a 66 year old male, was admitted to the Intensive Care Unit (ICU) on May 29, 2007, after an emergency tracheostomy (a tube into the trachea for breathing) was performed in the ED. On the "I.C.U./P.C.U. Flow Sheet", dated May 29, 2007,	E1912	--When a physician does not respond timely to a page and the nurses have to run the chain of command as necessary to meet an urgent patient care need, they are supposed to generate a Healthcare Peer Review Report (HPRR). --The information in the HPRR goes to the physician's Department Chair to address with the physician informally. --The information in the HPRR is also kept for tracking purposes and for consideration during the physician's recredentialing process. --If a physician shows a trend of slow response to pages, then the Hospital holds a formal meeting with the physician to discuss the problem and corrective action, and the physician is monitored after that for a period of time to be sure there are no further delays in responding to pages. Department Managers/Directors reviewed with nursing staff members and Respiratory Care Professionals the process for running the chain of command and generating an HPRR when a physician does not respond timely to an emergency. Administration confirmed that training on the chain of command is also included in each	06/29/07 06/29/07

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E1912	Continued From Page 26 at 9:30 PM, the nurse documented that Patient 135 became agitated and was fighting the ventilator (breathing machine). The nurse also documented that the patient's attending physician and the pulmonologist were paged for assistance and there was no return call from either physician. During an interview with ICU RN 1 on May 30, 2007, at 9:50 AM, she stated that the pulmonologists took call for their own patients during the week, and the on-call pulmonologist covered on the weekends. When she was asked what they did when there was no pulmonologist on call due to the "voluntary" call system, she stated that they called the ED to see if there was somebody on call, and if not, they called all of the pulmonologists on staff until they found one that was available to help them. During an interview with the Chief Nursing Executive (CNE) on May 30, 2007, at 11:50 AM, the CNE stated that she received complaints from the nursing staff about the physicians not being available when the nurses called them. The CNE said the complaints were becoming "slightly more" in the ED, and "noticeably more" in the ICU. The CNE stated that there was no particular day of the week, time of day, or specialty that was complained about more. She stated it seemed to be more of an "individual person problem." The CNE declined to give names of the physicians the nursing staff complained about. Further review of the Medical Staff Bylaws (revised 5/22/06) on May 30, 2007, at 3:15 PM. showed that: a. Section 3.7; "Each member of the medical staff shall retain responsibility, within his or her	E1912	annual competency update that all staff members complete. The Risk Management Department is responsible for monitoring HPRRs to determine whether any physician shows a trend of delay in response to calls from the Hospital. Risk Management reports to the PI/RM Committee, which reports as appropriate to the MEC and Governing Body. The Department of Medicine met and discussed methods for making it more efficient for nursing staff to reach the physicians with calls about inpatients. The Chair of the Department of Medicine is responsible for notifying all members of the Department about how to make it easier for the Hospital nursing staff to reach them when calling about inpatients under their care. The CNE is responsible for updating the intranet phone list that nurses use to contact physicians so that the list reflects the changes the physicians are making to enable nursing staff to reach them more quickly and easily. The CNE provided reminder education to nursing staff, and particularly to ICU nursing staff, about calling codes promptly what a patient becomes emergent.	06/29/07 & ongoing 08/01/07 08/31/07 09/15/07 08/30/07

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E1912	Continued From Page 27 area of professional competence, for the continuous care and supervision of each patient in the hospital for whom he or she is providing services, or arrange for a suitable alternative to assure such care and supervision." b. Section 4.2.3; "Each active Medical Staff Member shall actively participate on and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including, but not limited to emergency services and back-up functions ... c. Section 10.5.3; "A supervisory (departmental) committee shall conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department." d. Section 10.8.5; The duties of department chairs include, "Generally monitor the quality and appropriateness of patient care and professional performance provided by members with clinical privileges in the department ...and oversee the effective conduct of patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee," and also, "enforce Medical Staff Bylaws, Rules and Regulations and policies within the department ..." and, "provide for continuous assessment and improvement of the quality of care and services provided." The Performance Improvement Committee shall, "establish systems to identify potential problems in patient care and general areas of potential risk in clinical aspects of patient care and safety."	E1912	ALLEGATION OF COMPLIANCE The Hospital disagrees that it violated this rule related to assuring physician coverage for intensive care services and that this citation constitutes immediate jeopardy. The Hospital requests an informal conference with the district administrator/district manager to contest or appeal this alleged violation as well as the finding of immediate jeopardy related to this citation. As described above, the Hospital has emergency physicians in house 24/7 at both campuses and they are available to respond to emergencies for inpatients. There are also processes where by the on-call specialists are obligated to respond to inpatient needs if the patients do not have appropriate specialists available to meet there needs. Through this system, the Hospital assures physician coverage for inpatients. As further proof of compliance and absence of immediate jeopardy, the Hospital has provided additional relevant information that confirms the hospital's compliance with the regulation or misstatements in the survey report: Patient #135: The medical record for this patient documents that the patient came through the ED on May 29, 2007, was admitted to an attending internist, was taken to surgery for an emergency tracheostomy, and then was admitted to the ICU at 1510 that same day. --The consulting pulmonologist was present in the operating room and wrote the initial ICU orders.	

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E1912	Continued From Page 28 Further review of ICU medical records on May 30, May 31 and June 1, 2007, at IVMC, showed the following: a. Patient 201, a 76-year-old male was admitted to the ICU on May 24, 2007, with a preliminary diagnosis of Epidural Abscess (collection of pus near the spinal cord). A neurology consultation, dated May 24, 2007, was handwritten in the physician's progress notes. A transcribed, dictated and very detailed neurology consultation was in the medical record, also dated May 24, 2007. The transcribed consultation note was identified as being performed by Physician A. At the end of the dictated consultation, Physician A noted that he would be going out of town, and had notified the admitting physician. b. Patient 202, an elderly gentleman with left-sided weakness and pneumonia was hospitalized in ICU at IVMC during the time of survey. On May 31, 2007, at 8:15 AM, Patient 202 suffered a deterioration of his respiratory status. The nurses notes contained the timeline of events. Physician H, a neurologist, was at the bedside of Patient 202 when the nurses called Physician F, a Pulmonologist/Intensivist, also Medical Director for Respiratory Services, for assistance with an emergency intubation (placement of a breathing tube into the lungs). According to the nurses notes, Physician F was unavailable to come to the hospital. The nurses then paged Physician I to assist with an emergency intubation. Physician I is also a Pulmonary/Critical Care specialist, although he was not listed on the on-call schedule. The nurses informed Physician I that the patient required emergency intubation, but he was unavailable to come to the hospital at that time. A code blue (patient needing resuscitation team)	E1912	--The record further reflects that the anesthesiologist and pulmonologist remained in the ICU for a period of time after the patient's admission to assist with stabilizing him. --At 2100, the medical record documents that the patient was becoming restless. --At 2130, the nurses paged the attending physician and the pulmonologist because the patient started bucking the ventilator and the nurses needed orders for medication to calm the patient. --At 2205, the nurses spoke with the surgeon on the case and obtained the necessary medication orders. There was no documentation indicating that the nurses paged the attending physician or pulmonologist again (which they obviously did not need to do). At this point, there was no need to document if those physicians responded after the conversation with the surgeon and no need to run the chain of command, which would have triggered the HPRR. --The medical record also does not indicate the patient was having an emergency; vital signs were stable and the patient was described only as "restless" when medicated with Ativan 5 minutes later. Hospital staff confirmed that if the nurses required emergency help, they would have called other members of the healthcare team, run the chain of command, and if necessary, also been able to call one of the ED physicians, who are in house 24/7, 365 days/year, to provide assistance.	

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E1912	Continued From Page 29 was called and physician J, an ED physician, responded and intubated the patient at approximately 9:05 AM, 50 minutes after the patient was identified to be in severe respiratory distress requiring mechanical ventilation (breathing machine). During an interview with the Director of ICU on May 31, 2007, at 10:20 AM, she stated that she got feedback, from the nurses, for all of the problems that arose in the ICU. According to the Director, the ICU nurses were having a great deal of difficulty getting a pulmonologist to assist with ventilator management up until approximately two months ago. The Director stated with the addition of a new pulmonologist, the problem had improved. She stated she received approximately two calls per month from the ICU nursing staff related to this problem. She stated that when the ICU staff needed to know who was on call for a specialty, they usually knew by "word of mouth." If not, they called the ED for information. If the ED could not help, they called the offices for that particular specialty and inquired. If the offices didn't know, they went "down the list" and called all of the physicians in that specialty to see if they could get assistance. If they were still unable to get a specialist, they called the ICU Medical Director. The ICU Director stated that when the nursing staff had a delay in getting a response from a physician, they were supposed to write an HPRR (Healthcare Peer Review Report), that was reviewed and investigated by the clinical lead, and forwarded to the Performance Improvement Department. The ICU staff meeting minutes, dated April 19, 2007, were reviewed on May 31, 2007, at 10:50 AM. Under Department Issues, there was a discussion regarding "nurse apathy". The first	E1912	Patient #201: This patient was thoroughly evaluated by a consulting neurologist on 5/24, and the neurologist followed up concerning the status of the patient on 5/25. The neurologist timely dictated his consultation report and notified the patient's attending physician that he would be out of town starting on 5/25. The patient's chart in fact reflects that the consulting neurologist had appropriately notified the admitting physician that he would be out of town and identified other neurologists who would be available to see the patient if necessary. The patient was followed by one of the back-up neurologists on 5/26, although the patient was not having a neurological crisis of any kind. Patient #202: As required by California regulations, the ED physician was available and responded to the patient's needs when a consulting specialist physician at the patient's bedside was not able to intubate the patient and consulting pulmonologists were not present in the Hospital to respond to the patient's emergency needs. Patient #44: This record indicates that the nurse was calling the consulting pulmonologist to report the results of the patient's morning labwork and the fact that the patient was doing well on the ventilator. The consulting pulmonologist responded to the call timely within 30 minutes and asked the nurse to report the results to another pulmonologist who was covering for him/her that day. The second pulmonologist responded to the page timely within 20 minutes. When the on-call pulmonologist was reached, the physician determined that the patient was stable and gave no new orders.	

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E1912	Continued From Page 30 causative factor of nurse apathy was listed as "MD's do not seem to have accountability, do not answer pages, pass the buck, change phone numbers constantly". During an interview with ICU RN 2 on May 31, 2007, at 11:05 AM, ICU RN 2 stated that she remembered the April 19 staff meeting when the physician accountability was discussed. ICU RN 2 stated that if they need a specialist, they usually "just know who to call". If they did not know, ICU RN 2 stated, "we sometimes have to call all of the doctors on the list for that specialty". She stated that the problem had not improved yet. During an interview with ICU RN 3 on May 31, 2007, at 11:15 AM, ICU RN 3 stated that she remembered the April 19 staff meeting where the physician accountability was discussed. ICU RN 3 stated that the problem was worse for the night shift, and on the weekends. She stated that the nurses got tired and frustrated, and "we just want to take care of our patients, and the doctors don't care". ICU RN 3 stated that she had completed HPRR's regarding her inability to reach the physicians. The Director of Respiratory Services was interviewed on May 31, 2007 at 3:25 PM. He stated that in the event a patient on a ventilator needed a change in the machine settings, the pulmonologist on call would be contacted. If there was no pulmonologist on call, or if there was no response to to a page, the Respiratory Therapist would call the Respiratory Medical director, Physician F. physician F is board certified in pulmonology and Critical Care. If he was not available, then the "Chain of Command" was initiated.	E1912	The cited examples do not support a finding of noncompliance with this regulation or immediate jeopardy. For these reasons, the Hospital requests that this citation be removed.	

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E1912	Continued From Page 31 The Medical Director of the ED (also a member of the Board of Directors) was interviewed on May 31, 2007, at 1:20 PM. He stated that the voluntary call system was "inconvenient" and that often patients were transferred for the lack of an available specialist. He stated that "It's a problem" and that he had empathy for the patients. He stated the primary issue was customer satisfaction. He stated that although many specialties did not have a physician on-call, Urology was the most common specialty to have nobody who would come in to see a patient. He stated the problem with ventilated patients had improved since Physician D joined the pulmonary/intensive care team. However, Physician D was only on-call one week every four weeks. He stated that the ED physicians were "working with what we have to work with." He further stated that no Quality Assurance/Performance Improvement (QAPI) activities were being done to determine the effect the voluntary call system had on patient care, transfers or time spent trying to find a consultant. The Medical Director stated that he spoke at one of the Medical Executive Committee (MEC) meetings, and he told the committee about the difficulty dealing with the voluntary call system; "but until you are in my shoes, looking into the patient's eyes, you cannot know how we (the ED physicians) feel." Findings at RSMC: During a review of ICU medical records on June 1, 2007, the following was noted: Patient 44, a 91 year old male, was admitted to the ICU on May 31, 2007, on a ventilator (breathing machine). On June 1, 2007, at 6 AM, the ICU nurse paged Pulmonologist #1, who had done the initial pulmonary consult for ventilator	E1912		

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E1912	Continued From Page 32	E1912		

management, to report blood gas results (to show how well the ventilator is assisting the lungs). There was no response, so the ICU nurse repaged Pulmonologist #1 at 6:20 AM. At 6:30 AM, Pulmonologist #1 called back and said he was not on call, but Pulmonologist #2 was. At 6:35 AM, the ICU nurse paged Pulmonologist #2. At 6:45 AM, there was no response from Pulmonologist #2, so the nurse paged again. At 6:45 AM, there was still no response from Pulmonologist #2, so the ICU nurse paged the house supervisor for assistance. At 6:50 AM, Pulmonologist #2 returned his page to the ICU nurse.

During an interview with ICU RN 4 on June 1, 2007, at 11:50 AM, the nurse stated that the pulmonology service had been a problem when they were trying to get somebody to manage the patient on a ventilator, but their biggest problem was with neurology. She stated that the neurologists did not have to be on call, and MD 3 told them that he did not have to take call, so if he did not want to come in, he did not have to. ICU RN 4 stated that the ICU nurses made multiple phone calls, and spent hours of their days on the telephone trying to get in touch with doctors.

Physician B, a neurologist who provided services at both hospitals, was interviewed on June 1, 2007 at 1:55 PM, by telephone. He stated that there were four neurologists on staff, and that they went to a voluntary call schedule because the call was causing "burn out" among the physicians. Physician B stated the ED physicians were "pathological dumpers" who didn't want to work-up the patients in the ED. He emphasized that the hospital was not supporting them. He also stated that the administration had arranged call coverage with a new contracted

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E1912	Continued From Page 33 neurologist, but that she was unavailable to come to the facility when she was supposed to be on call, stating that she was not on call, or in Los Angeles. Physician B recommended the survey team review the chart of Patient 201. Reportedly, Patient 201 was an inpatient in the ICU at IVMC. The neurologist involved in the case told the admitting physician that he would be out of town. When a neurologist was urgently needed, the contracted physician was contacted, but was unable or unwilling to come to the facility to provide consultative services for Patient 201. During an interview with ICU RN 5 on June 1, 2007, at 2:43 PM, she stated that she wrote a verbal order for a neurology consult that morning for MD 4 to do. She stated she called MD 4, and was told that MD 5 was on call for neurology, so to call that physician instead. ICU RN 5 called MD 5, and was told that MD 3 was on call for neurology, so call that physician instead. ICU RN 5 stated that if she needed to know who was on call for a specialty, she called the offices and asks if they knew. When she was asked who was on call for neurology that day (June 1, 2007), she answered, "I guess it's MD 3". ICU RN 5 stated that she did not have a call list, but she could call the ED to see who was on call. When she was asked if she was aware that there was nobody on call for neurology for the ED, she stated, "no". In the ICU on June 1, 2007, at 2:52 PM, in the presence of four ICU nurses and three ICU managers, a general question was asked of them, how much time do you spend making calls to try to find physicians? They all answered, "a lot". Physician G, an Internal Medicine doctor serving both hospitals, was interviewed on June 1, 2007	E1912		

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E1912	Continued From Page 34 at 3:25 PM at RSMC. He stated that there had been a "couple of instances" when he had a patient who needed a Neurology consult and was unable to obtain one. He also said that he generally called Physician F when he needed a pulmonology/critical care consult, bypassing the on-call schedule, because he got a better response. He added that "In general, it is not easy to get consultations at this hospital." He also stated that there was poor communication between doctors and administration.	E1912		

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A 000	INITIAL COMMENTS The following reflects the findings of the California Department of Health Services during a Complaint Validation Survey (complaint numbers 115208 and 116136) authorized by the Centers for Medicare and Medicaid Services (CMS), Region IX. The Southwest Healthcare System is comprised of two hospitals, Inland Valley Medical Center (IVMC) and Rancho Springs Medical Center (RSMC). The survey was conducted at IVMC on May 30 and 31, 2007, and concluded at RSMC on June 1, 2007. On May 30, 2007, at 2:35 PM, Immediate Jeopardy was identified regarding the Condition of Participation: Emergency Services. IVMC and RSMC are under one provider number and share administrative, medical and nursing staff. It was determined that the same conditions existed at IVMC and RSMC, so the Immediate Jeopardy included both facilities. The Immediate Jeopardy was not abated by the survey exit date of June 1, 2007. Representing the Department: Tina Buchanan, HFEN; Carolyn McHugh, HFEN; and Morton Kligerman, MD, MPH, Medical Consultant.	A 000	By submitting this plan of correction, the Hospital does not agree that the citations are correct or that it violated the rules. The Hospital specifically does not agree that there was or is an immediate jeopardy with respect to emergency services. Please see credible allegation of compliance following each description of corrective action the Hospital has taken to address the concerns of the surveyors.	
A 186	482.22(c) MEDICAL STAFF BYLAWS The medical staff must adopt and enforce bylaws to carry out its responsibilities. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the medical staff enforced their bylaws/rules and regulations in regard to physician on-call coverage by specialists with active and provisional privileges at the facility.	A 186	RULES REVIEWED BY THE GOVERNING BODY (Corrective Action begins on page 2): The Governing Body reviewed the Medicare requirements for Medical Staff Bylaws as follows: §482.22(c) Standard: Medical Staff Bylaws: "The medical staff must adopt and enforce bylaws to carry out its responsibilities. ..."	06/18/07

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

Linda Bradley — CEO/MANAGING DIRECTOR — 7/12/07

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.

ACCEPTABLE

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A 186	Continued From page 1 Findings: On May 30, 2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated that the practice for the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the Governing Body initially approved the voluntary call system on a trial basis for 90 days, and subsequently extended the trial time on two separate occasions. At this time, the on-call physician coverage remained voluntary. The meeting minutes for the Family Practice Department were reviewed on May 30, 2007. In the minutes dated November 29, 2006, there was a report by ED Physician B for ED Physician C, that advised, "Since call is currently voluntary, written agreements are currently in progress by administration for specialists. We currently do not have a formal call panel for Neurology, ENT, Pulmonology, and Ophthalmology, causing patients to be transferred. The minutes for March 2007 were also reviewed. In the first paragraph of the executive session was the statement, "The department noted that neurosurgeons have the choice to respond or not to a consult request." On May 30, 2007, the Medical Staff Bylaws, that were revised on February 22, 2007, were reviewed. The Bylaws specified, "Each active medical staff member shall: ...Actively participate on, and cooperate with the Medical Staff to assist the Hospital in fulfilling its obligations related to patient care, including but not limited to emergency services and back-up functions...Provisional members seeking Active	A 186	Interpretive Guidelines §482.22(c): "The medical staff must develop and adopt bylaws, and after the hospital's governing body approves the bylaws, the medical staff must enforce its bylaws." Survey Procedures §482.22(c): "• Verify that the medical staff have bylaws. "• Verify that the bylaws describe a mechanism for ensuring enforcement of its provisions along with rules and regulations of the hospital. "• Verify that the medical staff enforce the bylaws." ACTIONS TAKEN IN RESPONSE TO A 186: The Hospital Governing Body and MEC leadership reviewed and confirmed that the Medical Staff as a whole is responsible for providing medical care to address the emergency needs of patients, including both inpatients and emergency department (ED) patients. The Hospital Governing Body and MEC leadership reviewed and confirmed that physicians who admit their patients to the Hospital must be available to provide care for their patients in a timely manner or arrange for an alternate practitioner who has equivalent clinical privileges at the Hospital. The Hospital Governing Body and MEC leadership reviewed and confirmed that participation on the call panel for the ED is not mandatory at this time, but that when a physician agrees to participate on the call panel and is on call for the ED, the physician MUST respond to the Hospital timely when called, MUST come to the Hospital timely to render care when requested, and MUST see all unassigned patients as requested.	06/18/07 06/18/07 06/18/07

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A 186	Continued From page 2 staff membership shall participate in emergency services and back-up functions." On May 30, 2007, a review of the current Medical Staff Rules and Regulations, that were revised May 22, 2006, showed that: a. Section 1.3.2: "Each practitioner must be available to provide professional care for his/her patients in a timely manner (30 minutes) or arrange for an alternate practitioner who has equivalent clinical privileges at the hospital." b. Section 2.1.1: "A call panel has been established for referring patients who need hospital care to qualified medical staff members. Service on the call panel is not a privilege, but is an obligation of staff membership." c. Section 2.2.1: "Practitioners on call must respond promptly when requested to see a patient. Practitioners, including specialty consultants, must respond initially by phone or in person within approximately 30 minutes of the time the request to respond is made." d. Section 2.2.3: "When scheduled on call, each practitioner shall accept the care of all patients who are appropriately referred..." e. Section 2.2.4: "The on call specialist must also be available for inpatients. If no other specialist in that specialty is willing or able to provide care for a particular inpatient, the on call specialist has the obligation to see that patient to treat, stabilize or appropriately transfer the patient in a timely manner." f. Section 2.2.7: "A patient will be admitted in the	A 186	The Hospital Governing Body and MEC reviewed and confirmed the Medical Staff Bylaws and Rules and Regulations provisions regarding the timeframe for responding to calls from the Hospital regarding the emergency needs of patients (both inpatients and ED patients): --Physicians with admitted patients must respond timely (within 30 minutes) or arrange for another comparable physician to take call and respond timely, AND --Physicians on call for the ED must respond by phone or in person within 30 minutes, and must come to the Hospital within 30 minutes to render care when asked to do so. When the on-call physician has responded first by telephone, he/she can give direction/orders for testing or interventions (as appropriate) while the physician is traveling to the Hospital. The Medical Staff members of the Governing Board drafted and circulated a letter to all Medical Staff members reminding them that they must respond at least by telephone to calls from Hospital staff about their inpatients, and when they are on call for the ED, they must respond by telephone or in person to calls from the ED within 30 minutes, and must come to the ED within 30 minutes when requested. The letter was mailed, faxed, placed in physicians' mailboxes, and posted in all physician areas at both Hospital campuses. SEE EXHIBIT A. The Governing Body approved the recommendations of the Department of Medicine and of the MEC to grant the requests of several internal medicine physicians for additional privileges to manage ventilator patients. As part of this recommendation and approval process, the Department of Medicine, the MEC, and the Governing Body reviewed the categories of physicians allowed to hold	06/18/07 06/21/07 06/18/07

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A 186	Continued From page 3 name of the call panel practitioner. The call panel practitioner must be notified about each admission to his service prior to the patient leaving the Emergency Department, and following a discussion with the Emergency Department physician." The medical record for Patient 135 was reviewed on May 30, 2007. Patient 135, a 66 year old male, was admitted to the Intensive Care Unit (ICU) on May 29, 2007, after an emergency tracheostomy (a tube into the trachea for breathing) was performed in the ED. On the "I.C.U./P.C.U. Flow Sheet", dated May 29, 2007, at 9:30 PM, the nurse documented that Patient 135 became agitated and was fighting the ventilator (breathing machine). The nurse also documented that the patient's attending physician and the pulmonologist were paged for assistance and there was no return call from either physician. During an interview with ICU RN 1 on May 30, 2007, at 9:50 AM, she stated that each pulmonologist took call for their own patients during the week, and the on-call pulmonologist covered on the weekends. RN 1 was asked what the staff did when there was no pulmonologist on call due to the "voluntary" call system. She stated that the staff called the ED to find out if there was a pulmonologist on call, and if not, they called all of the pulmonologists on staff until they found one that was available to help. During an interview with the CNE on May 30, 2007, at 11:50 AM, the CNE stated she received complaints from the nursing staff about the physicians not being available when the nurses called them. The CNE said the complaints were becoming "slightly more" in the ED, and	A 186	ventilator management privileges at multiple hospitals in the surrounding areas. Additionally, these groups recognized that privileges were appropriate for physicians whose scope of practice encompasses this area of patient care management, and that ventilator management is by far the most common emergent need associated with pulmonary care. --These physicians had demonstrated competency and submitted their requests for additional privileges before the survey, and the process did not happen to be completed until after the survey. --The granting of these additional privileges increased the pool of consultants available to attending physicians who need assistance with ventilator management, of physicians with ventilator management credentials taking call for the ED, and of qualified physicians available to Hospital Administration and Medical Staff leadership if nursing staff invokes the chain of command to address a patient's sudden change in condition, as described below. Administration and ED Physician Leadership revised the on-call roster for the ED so that a pulmonologist or internist privileged to manage patients on ventilators was on call almost 24/7 for the next month, with the goal of providing ventilator management coverage 24/7, 365 days a year going forward. Administration reviewed and confirmed the Hospital has an effective process for obtaining timely assistance from physicians for inpatients with emergency needs: --As has long been the standard of practice, attending physicians direct the care of their patients and are responsible for obtaining consults by specialists, as they deem necessary, and for arranging coverage for themselves when they are not available. If an inpatient has an	07/03/07 06/18/07

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	Continued From page 4		emergency, the nursing staff first calls the attending physician or the physician covering for the attending. --Other physicians already consulting on the patient's treatment team are likewise obligated to respond if called and to provide coverage for themselves. --As a backup in an emergency, there is an ED physician in-house at each hospital, 24/7, 365 days a year. --As further backup, if there is a need for a specialist not already consulting on the case, the nursing staff may contact the appropriate physician on the on-call panel for the ED if one is on the schedule, because as the 2567 notes, section 2.2.4 of the Medical Staff Rules states that assisting with inpatient emergencies is a requirement for any physician while on call for the ED. --Because there may be occasions when there is not on-call coverage for the ED in the desired specialty, there is a need for a specialty consultant to address an emergency, and the attending physician has not found a consultant, the nursing staff can run the chain of command to get medical staff assistance with finding a consultant. --As a final and rare option, the Hospital may arrange to transfer the patient to another facility that can address the patient's problem. Administration reviewed and confirmed that the Hospital has an effective system in place for enforcing these requirements. The chain of command assists the nursing staff in responding to the needs of patients, and the reporting and monitoring system is the tool for enforcing the Bylaws provision as follows:	06/18/07

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	Continued From page 4A		--When a physician does not respond timely to a page and the nurses have to run the chain of command as necessary to meet the patient's needs, they are supposed to generate a Healthcare Peer Review Report (HPRR). --The information in the HPRR goes to the physician's Department Chair to address with the physician informally. --The information in the HPRR is also kept for tracking purposes and for consideration during the physician's recredentialing process. --If a physician shows a trend of slow response to pages, then the Hospital holds a formal meeting with the physician to discuss the problem and corrective action, and the physician is monitored after that for a period of time to be sure there are no further delays in responding to pages. Department Managers/Directors reviewed with nursing staff members and Respiratory Care Professionals the process for running the chain of command and generating an HPRR when a physician does not respond timely to an emergency. Administration confirmed that training on the chain of command is also included in each annual competency update that all staff members complete. The Risk Management Department is responsible for monitoring HPRRs to determine whether any physician shows a trend of delay in response to calls from the Hospital. Risk Management reports to the PI/RM Committee, which reports as appropriate to the MEC and Governing Body.	06/29/07 06/29/07 06/29/07 & ongoing

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	Continued From page 4B		ALLEGATION OF COMPLIANCE WITH A 186: The Hospital nevertheless respectfully disagrees that the cited example supports the allegation that the Hospital was not enforcing the Bylaws requirement and not attending to the emergency needs of patients for the following reasons: --With patient #135, the medical record documents that the patient came through the ED on May 29, 2007, was admitted to an attending internist, was taken to surgery for an emergency tracheostomy, and then was admitted to the ICU at 1510 that same day. --The consulting pulmonologist was present in the operating room and wrote the initial ICU orders. --The record further reflects that the anesthesiologist and pulmonologist remained in the ICU for a period of time after the patient's admission to assist with stabilizing him. --At 2100, the medical record documents that the patient was becoming restless. --At 2130, the nurses paged the attending physician and the pulmonologist because the patient started bucking the ventilator and the nurses needed orders for medication to calm the patient. --At 2205, the nurses spoke with the surgeon on the case and obtained the necessary medication orders. There was no documentation indicating that the nurses paged the attending physician or pulmonologist again (which they obviously did not need to do). At this point, there was no need to document if those physicians responded after the conversation with the surgeon and no need to run the chain of command, which would have triggered the HPRR.	

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	Continued From page 4C		--The medical record also does not indicate the patient was having an emergency; vital signs were stable and the patient was described only as "restless" when medicated with Ativan 5 minutes later. Hospital staff confirmed that if the nurses required emergency help, they would have called other members of the healthcare team, run the chain of command, and if necessary, also been able to call one of the ED .physicians who are in house 24/7, 365 days/year, to provide assistance. The cited example does not support a finding of immediate jeopardy or of noncompliance with the CoPs, or the conclusion that the Hospital was not attending to the emergency needs of inpatients. For these reasons, the Hospital requests that this citation be removed.	

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A 186	Continued From page 4 "noticeably more" in the ICU. The CNE stated that there was no particular day of the week, time of day, or specialty that was complained about more. She stated it seemed to be more of an "individual person problem." The CNE declined to give the names of the physicians the nursing staff complained about.	A 186		
A 452	482.55 EMERGENCY SERVICES The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to ensure that Emergency Services were provided in a manner that met the needs of the patients in accordance with acceptable standards of practice for the provision of on-call physician coverage to the Emergency Department (ED) for services that the facility offered to the public. The facility failed to ensure that: 1. The Medical Staff provided ongoing and continuing assessment of the medical care provided in the ED to establish and/or revised policies and procedures governing the ED medical care based on Quality Assurance and Performance Improvement. (A0456). 2. There was adequate on-call physician coverage for patients in need of specialized treatment when the facility had the capacity to treat the individual (A0459). 3. The Medical Staff enforced their Bylaws in regards to backup emergency call coverage by specialists on staff at the facility (A0186).	A 452	RULES REVIEWED BY THE GOVERNING BODY (Corrective Action begins on page 5): The Governing Body reviewed what the Medicare rules state is required to "meet the emergency needs of patients in accordance with acceptable standards of practice:" "'Acceptable standards of practice' includes maintaining compliance with applicable Federal and State laws, regulations, and guidelines regarding hospital emergency services, as well as any standards or recommendations promoted by or established by nationally recognized professional organizations (e.g., American Medical Association, American Nurses Association, American College of Emergency Medicine, etc.). "The hospital's emergency services must be integrated into the hospital-wide QAPI program. "The medical staff is responsible for the quality of care provided to its patients. Appropriate provisions for follow-up care for emergency patients, who are not admitted to the hospital or transferred to another hospital, must be made." ACTIONS TAKEN IN RESPONSE TO A 452: The Governing Body met to review the citations and the options for addressing the identified deficiencies. The Governing Body also	06/18/07 06/18/07

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A 452	Continued From page 5	A 452	considered the factors that CMS has set forth in the State Operations Manual concerning emergency services and on-call requirements. The Governing Body noted specifically the CMS Interpretive Guidelines that explain what is meant by meeting patients' emergency needs in accordance with acceptable standards of practice. The Governing Body noted that the Emergency Medical Treatment and Labor Act (EMTALA) addresses specific on-call requirements for hospitals furnishing emergency services, and that the 2567 does not cite any other acceptable standards of practice. Please see specific actions taken and allegations of compliance under A 456, A 459, and A 186.	06/18/07 06/18/07

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A 452	Continued From page 5 The cumulative effect of this systemic problem resulted in the failure of Emergency Services to ensure that patients received quality medical care in a safe patient environment.	A 452		
A 456	482.55(a)(3) POLICIES The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the medical staff provided ongoing and continuing assessment of the medical care provided in the Emergency Department (ED), and established and/or revised the policies and procedures regarding practices in the ED based on Quality Assurance and Performance Improvement (QAPI) activities. Findings: On May 30, 2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated the practice for the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the Governing Body initially approved the voluntary call system on a trial basis for 90 days, and subsequently extended the trial time on two separate occasions. The current on-call physician coverage for the facility was voluntary. On May 30, 2007, the Medical Staff Bylaws that were revised on February 26, 2007, were reviewed. The Bylaws specified, "Each active	A 456	RULES REVIEWED BY THE GOVERNING BODY (Corrective Action begins on page 6): The Governing Body reviewed the CMS Interpretive Guidelines regarding the responsibility of the Medical Staff with respect to ongoing and continuing assessment of medical care provided in the ED: Interpretive Guidelines §482.55(a)(3): "The hospital's medical staff must establish policies and procedures governing the medical care provided in the emergency service or emergency department. The medical staff must have had ongoing/continuing assessment of the medical care provided in the emergency service or department. Emergency service or emergency department policies must be current and revised as necessary based on the ongoing monitoring conducted by the medical staff and the emergency service or department QAPI activities." Survey Procedures §482.55(a)(3): "Verify that procedures and policies for emergency medical services (including triage of patients) are established, evaluated, and updated on an ongoing basis." ACTIONS TAKEN IN RESPONSE TO A 456: The Hospital's Governing Body and Medical Executive Committee (MEC) reviewed and confirmed that Medical Staff departments, including the ED Department, regularly review medical care furnished to ED patients. --ED PI activity is completed regularly on specific cases.	06/18/07 06/26/07

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A 456	Continued From page 6 medical staff member shall actively participate on, and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including but not limited to emergency services and back-up functions....Provisional staff members seeking Active staff membership shall participate in emergency services and back-up functions." The facility Performance Improvement Plan was reviewed on May 30, 2007. The plan included the following: 1. Objectives for provision of care which included: a. A mechanism to assure that all patients received the same level of care; and b. A culture where care was delivered in a safe environment, and quality care was measured, monitored and continuously improved. 2. The responsibilities of the Governing Board included a duty to assure patient care was safely delivered within the guidelines established by the Medical Staff. 3. The Medical Executive Committee of the Medical Staff was accountable to the Governing Board to ensure care was delivered in accordance with the Medical Staff Bylaws, Rules and Regulations. 4. Measuring and monitoring performance included ensuring that processes, functions or services were designed/redesigned well, and met the needs of the individuals served. The ED Quality Assurance/Performance Improvement (QAPI) was reviewed on May 30, 2007. The ED was monitoring compliance with EMTALA transfer regulations, on a quarterly	A 456	--Data is trended and monitored regarding the number of ED patients seen and the number of transfers occurring, among other things. --Data is tracked at the ED level, and information is reported up through the ED Department to the MEC, and then to the Governing Body as indicated. --Cases of concern may also be referred to the PI/RM Committee for peer review. The Hospital's Governing Body and MEC reviewed and confirmed that the QAPI system was monitoring the completeness of transfer documentation, as noted in the citation. The Hospital Governing Body and MEC leadership reviewed and confirmed that participation on the call panel for the ED is not mandatory at this time, but that when a physician agrees to participate on the call panel and is on call for the ED, the physician MUST respond to the Hospital timely when called, MUST come to the Hospital timely to render care when requested, and MUST see all unassigned patients as requested. Administration analyzed transfers for the previous 3 months with a focus on several subspecialties that have little to no coverage, and determined that the majority of transfers were for services the Hospital does not offer (e.g., interventional cardiology, psychiatry, neonatal intensive care (NICU) services), and confirmed that only a very small percentage of transfers occurred because the ED lacked specialist coverage at the time. The Hospital's Governing Body reviewed and confirmed that: --The ED sees approximately 5,000 patients a month;	06/26/07 06/18/07 06/01/07 06/18/07

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A 456	Continued From page 7	A 456	--The ED transfers a very small percentage of those patients because the Hospital maintains 24/7, 365 days/year coverage for multiple specialist categories that address most emergent needs (e.g., Internal Medicine/Family Practice, Pediatrics, OB/Gyn, General Surgery, Trauma Surgery; Neurosurgery (except 3-4 days/month), Orthopedic Surgery, Cardiology, and Anesthesiology); --The majority of transfers from the ED are because the patient needs a service the Hospital does not offer, such as interventional cardiology, psychiatry, or neonatal intensive care (NICU) services. --The rate of transfers when physician participation in ED call coverage was mandatory was essentially the same as the rate of transfers under the current system where physicians may elect not to participate on the ED call panel (although as noted above, when a physician elects to take call for the ED, he/she MUST respond to the ED and care for unassigned patients as requested); --The specialties for which there is call coverage have not decreased in the last year, but in fact have increased with the addition of neurosurgery coverage. The "voluntary call" system has been workable because the medical staff has been able to provide 24/7 coverage for almost 365 days/year in the major areas identified above and in A 459; --Administration and Medical Staff leadership are in the process of negotiating further improvements to the call panel to include teleneurology coverage for the ED; a NICU is currently under construction, and interventional.cardiology is scheduled to begin construction in 2008.	

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A 456	Continued From page 7A	A 456	Hospital Administration enhanced the ongoing monitoring of a random sample of transfers to evaluate: --The appropriateness of and reasons for transfers, with attention to transfers because the Hospital does not offer a particular service and because the ED lacks specialist coverage, and --Overall transfer rates.	06/29/07
			The PI/RM Committee is responsible for analyzing the monitoring results, for taking actions as appropriate, and for reporting information as indicated monthly to the MEC and, as appropriate, to the Governing Body, which meets 10 times during the year.	06/29/07 & ongoing
			The PI/RM Committee reviewed data on transfers and the reasons for transfer and drew the same conclusions noted above by Administration and the Governing Body. Please see further detail under responses to A 459 and A 186.	07/09/07
			ALLEGATION OF COMPLIANCE WITH A 456: The Hospital nevertheless respectfully disagrees that the citation supports a violation of this rule. Medical and administrative leadership regularly evaluate emergency coverage and anticipated emergency needs on an ongoing basis—as the surveyors saw, this ongoing evaluation is a regular topic of discussion at leadership meetings. The 2567 itself details one of the QAPI monitors used by the Hospital to evaluate transfers. Other monitoring also tracks the number of transfers. The Hospital has determined that it continues to see approximately 5,000 patients a month in the ED; that it transferred a small	

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A 456	Continued From page 7 basis, in the following areas: a. The patient's condition was documented; b. The accepting facility was documented; c. The accepting physician was documented; d. Appropriate paperwork was sent with the patient; e. The method of transportation was documented; f. Vital signs were done within 15 minutes of transfer; g. The physician defined the reason for transfer; and h. The consent was signed and witnessed. There was no monitoring regarding the reason for transfer, availability of on-call physician services, appropriateness of transfers or outcomes related to transfers. The Medical Staff and Governing Board had no QAPI data to assess the quality of care provided by the on-call physician services in the ED, or to determine if changes in policies were appropriate, necessary and would meet the needs of the individuals served. The facility transfer policy was reviewed on May 30, 2007. The policy stated that, "The policy and philosophy of Southwest Healthcare System (SWHCS), emergency services and care will be provided to any individual who requests services...." The policy also stated that, "Unless extenuating circumstances are present, no patient will be transferred to another facility if SWHCS has the means to provide the care." Some conditions that required transfer to another facility included, "If physician specialty is unavailable due to gaps in the on-call physician schedule..."	A 456	percentage of its ED patients when there was mandatory call; that it continues to transfer essentially the same small percentage of patients under the current system where physicians elect whether to participate on the call panel for the ED; and that the vast number of these transfers are for services the Hospital does not currently offer, such as psychiatry, interventional cardiology, and NICU services. This consistency in the data indicates that the shift to a system where physicians elect whether to be on the ED call roster has not changed the Hospital's call capability or increased the need to transfer patients. A majority of those transfers are necessary not because the Hospital does not have emergency coverage for a given specialty, but because the Hospital does not offer the service or procedure the patient needs. As a result of this analysis, the Hospital is taking steps to add identified specialties such as interventional cardiology and a NICU. For these reasons, the Hospital submits that there was no immediate jeopardy to patients at the time of the survey, nor is there now; that the Hospital was and is in compliance with the rules; and that this citation should be removed.	
A 459	482.55(b)(2) QUALIFIED PERSONNEL There must be adequate medical and nursing	A 459		

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A 459	Continued From page 8 personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate on-call physician coverage to meet the needs of patients presenting to the Emergency Department (ED). On May 30, 2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated the practice of the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the Governing Body initially approved the voluntary call system on a trial basis for 90 days, and subsequently extended the trial time on two separate occasions. At this time, the on-call physician coverage remained voluntary. The meeting minutes for the Emergency Medicine Department were reviewed on May 30, 2007, at 10:50 AM. The minutes, dated September 2006, included a section titled, "Call Panel Validation", which specified, "For physicians not on suspension, the ED had been calling to confirm assigned call. The CEO indicated she is working on a plan process for everyone and will give information to ED Medical Directors. The CEO indicated the verification of daily assigned call will not be through the Medical Staff Office." The meeting minutes for the Family Practice Department were reviewed on May 30, 2007, at 10:55 AM. In the minutes dated November 29, 2006, there was a report by ED Physician B for	A 459	RULES REVIEWED BY THE GOVERNING BODY (Corrective Action begins on page 12B): Regarding current call coverage for the Hospital, the Governing Body considered the following requirements of the Emergency Services Condition of Participation and of the more specific EMTALA rules, and reviewed the anticipated emergency needs of the Hospital's patients. Interpretive Guidelines §482.55(b)(2): "The hospital must staff the emergency department with the appropriate numbers and types of professionals and other staff who possess the skills, education, certifications, specialized training and experience in emergency care to meet the written emergency procedures and needs anticipated by the facility. "The hospital must determine the categories and numbers of MD/DOs, specialists, RNs, EMTs, and emergency department support staff the hospital needs to met its anticipated emergency needs. "The medical staff must establish criteria, in accordance with State law and regulations and acceptable standards of practice delineating the qualifications required for each category of emergency services staff (e.g., emergency physicians, specialist MD/DO, RNs, EMTs, mid-level practitioners, etc.). "As a suggested prudent practice the hospital should conduct periodic assessments of its emergency needs in order to anticipate the policies, procedures, staffing, training, and other resources that may be needed to address likely demands." Survey Procedures §482.55(b)(2): "Verify that there are sufficient medical and nursing personnel qualified in the needs	06/18/07

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A 459	Continued From page 9 ED Physician C, that advised, "Since call is currently voluntary, written agreements are currently in progress by administration for specialists. We currently do not have a formal call panel for Neurology, ENT, Pulmonology, and Ophthalmology, causing patients to be transferred. The minutes for March 2007 were also reviewed. In the first paragraph of the executive session there was the statement, "The department noted that neurosurgeons have the choice to respond or not to a consult request." On May 30, 2007, the current Medical Staff Bylaws that were revised on February 26, 2007, were reviewed. The Bylaws specified that, "Each active medical staff member shall actively participate on, and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including but not limited to emergency services and back-up functions....Provisional staff members seeking Active staff membership shall participate in emergency services and back-up functions." On May 30, 2007, the Emergency Department back-up specialty call schedules for April, May and June, 2007, were reviewed . The following specialties had no formal call panel: a. Allergy (one physician on staff); b. Dentistry (one physician on staff); c. Dermatology (one physician on staff); d. Endocrinology (three physicians on staff); e. Gastroenterology (eleven physicians on staff); f. Hematology/Oncology (seven physicians on staff); g. Infectious Diseases (two physicians on staff); h. Nephrology (three physicians on staff); i. Neurology (three physicians on staff); j. Ophthalmology (three physicians on staff);	A 459	anticipated by the facility and that there are specific assigned duties for emergency care personnel and a clear chain of command. "Interview staff to determine that they are knowledgeable, within their own level of participation in emergency care including: "• Parenteral administration of electrolytes, fluids, blood and blood components; "• Care and management of injuries to extremities and central nervous system; "• Prevention of contamination and cross infection." §489.24(j) Availability of On-Call physicians "(j) Availability of on-call physicians. "(1) Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians." Interpretive Guidelines: §489.24(j)(1): "Hospitals have the ultimate responsibility for ensuring adequate on-call coverage. Hospitals participating in the Medicare Program must maintain a list of physicians on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an EMC. Hospitals have an EMTALA obligation to provide on-call coverage for patients in need of specialized treatment if the hospital has the capacity to treat the individual. "No physician is required to be on-call at all times. On-call coverage should be provided for within reason depending upon the number of physicians in a specialty....The surveyor will consider all relevant factors including the number of physicians on staff, the number of	

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A 459	Continued From page 10 k. Oral Surgery (three physicians on staff); l. Pain Management (four physicians on staff); m. Plastic Surgery (six physicians on staff); n. Podiatry (nine physicians on staff); o. Psychiatry (one physician on staff); p. Pulmonology (four physicians on staff); q. Radiation Oncology (three physicians on staff); r. Rheumatology (one physician on staff); s. Urology (five physicians on staff); and, t. Vascular Surgery (two physicians on staff). During a review of medical records on May 30 , 2007, the following was noted: a. Patient 119, a 26 year old male, presented to the ED on March 27, 2007, at 10:10 AM. The chief complaint was multiple seizures after arriving in the recovery room at a local surgery center. Patient 119 continued to have seizures during ambulance transport and on arrival to the ED. The ED physician diagnosed Patient 119 with Status Epilepticus (uncontrolled seizures). The ED physician's dictated report, dated March 27, 2007, showed Patient 119 and his family were informed of the treatment plan, "Including the potential for transfer to a tertiary care center for neurology, as we have no neurology on-call." The ED physician, "Spoke to a staff neurologist, however he was not on call, and agreed with the plan to transfer." The ED physician arranged for Patient 119 to be transferred to another facility accompanied by a critical care transport team. A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two neurologists on active staff, and two neurologists in provisional status seeking active staff membership.	A 459	physicians in a particular specialty, other demands on these physicians, the frequency with which the hospital's patients typically require services of on-call physicians, vacations, conferences, days off and the provisions the hospital has made for situations in which a physician in the specialty is not available or the on-call physician is unable to respond. "If a staff physician is on-call to provide emergency services or to consult with an emergency room physician in the area of his or her expertise, that physician would be considered to be available at the hospital. A determination as to whether the on call physician must physically assess the patient in the emergency department is the decision of the treating emergency physician.... "If a physician who is on-call does not come to the hospital when called, but rather repeatedly or typically directs the patient to be transferred to another hospital where the physician can treat the individual, the physician may have violated EMTALA. Surveyors are to assess all facts of the case prior to making a recommendation to the RO as to whether the physician violated EMTALA. Surveyors are to consider the individual needs and the physician circumstances, which may have an impact upon the case. Each case is to be viewed on its own merit and specific facts. "For physicians taking call simultaneously at more than one hospital, the hospitals must have policies and procedures to follow when the on call physician is not available to respond because he has been called to the other hospital to evaluate an individual. Hospital policies may include, but are not limited to procedures for back up on-call physicians, or the implementation of an appropriate EMTALA transfer according to 42 CFR §489.24(e). The policies and procedures a hospital adopts to	

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A 459	Continued From page 11 b. Patient 120, a 62 year old male, presented to the ED on April 2, 2007, at 11:58 PM, with a chief complaint of blindness in the right eye. The triage assessment, dated April 3, 2007, at 12:24 AM, showed Patient 120 had hit his head earlier in the day and developed a sudden loss of vision in his right eye at 10:30 PM. The ED physician's dictated report, dated April 3, 2007, showed that Patient 120 had signs of a retinal detachment and, "This institution does not have an ophthalmologist on call." At 7:43 AM, Patient 120 was transferred to another facility for a "higher level of ophthalmological care," nearly eight hours after arrival in the ED for treatment. A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two ophthalmologists on active staff, and one ophthalmologist in provisional status seeking active staff membership.	A 459	meet its EMTALA obligation is at the hospital's discretion, as long as they meet the needs of the individuals who present for emergency care taking into account the capability of the hospital and the availability of on-call physicians.... §489.24(j) Availability of On-Call physicians "(j) Availability of on-call physicians. "(2) The hospital must have written policies and procedures in place— "(i) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; Interpretive Guidelines: §489.24(j)(2)(i): "The medical staff by-laws or policies and procedures must define the responsibility of the on-call physicians to respond, examine and treat patients with an EMC. "Physicians, including specialists and subspecialists (e.g., neurologists) are not required to be on call at all times or required to be on call in their specialty for emergencies whenever they are visiting their own patients in the hospital. The hospital must have policies and procedures (including back-up call schedules or the implementation of an appropriate EMTALA transfer) to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control. The hospital is ultimately responsible for providing adequate on-call coverage to meet the needs of its patients. §489.24(j) Availability of On-Call physicians "(j) Availability of on-call physicians. "(2) The hospital must have written policies and procedures in place— "(ii) To provide that emergency services are available to meet the needs of patients with	

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A 459	Continued From page 12	A 459	emergency medical conditions if it elects to permit on-call physicians to schedule elective surgery during the time that they are on-call or to permit on-call physicians to have simultaneous on-call duties." Interpretive Guidelines: §489.24(j)(2)(ii): "Physicians are not prohibited from performing surgery while on-call. The only exception applies to Critical Access Hospital (CAH) staff. On-call physicians who are reimbursed for being on-call at CAHs cannot provide services at any other provider or facility. However, a hospital may have its own internal policy prohibiting elective surgery by on-call physicians to better serve the needs of its patients seeking treatment for a potential emergency medical condition. When a physician has agreed to be on-call at a particular hospital during a particular period of time, but has also scheduled elective surgery during that time, that physician and the hospital should have planned back-up in the event that he/she is called while performing elective surgery and is unable to respond to the situation or the implementation of an appropriate EMTALA transfer according to §489.24(e). "Physicians can be on-call simultaneously at other hospitals to maximize patient access to care. When the on-call physician is simultaneously on-call at more than one hospital in the geographic area, all hospitals involved must be aware of the on call schedule as each hospital independently has an EMTALA obligation. The medical staff by laws or policies and procedures must define the responsibilities of the on call physicians to respond, examine and treat individuals with emergency medical conditions, and the hospital must have policies and procedures to be followed when a particular specialty is not available or the on call physician cannot respond because of situations beyond his or	

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A 459	Continued From page 12A	A 459	her control as the hospital is ultimately responsible for providing adequate on call coverage to meet the needs of its individuals." ACTIONS TAKEN IN RESPONSE TO A 459: The Governing Body reviewed and confirmed the staffing of the ED with appropriate personnel and with ED physicians qualified to handle most emergencies. The Governing Body revisited the following key factors with respect to the Hospital's staffing of the on-call roster for the ED: --What specialties met the most frequent needs for emergency services and the fact that these specialties should be scheduled to be on call for the ED as close to 24/7, 365 days/year as possible. These specialties are: medicine/family practice, general surgery, orthopedics, obstetrics/gynecology, cardiology, trauma surgery, neurosurgery, pediatrics, and anesthesiology; --What services and facilities the Hospital offered, including the services and facilities the Hospital did not offer (e.g., the fact that the Hospital does not have a psychiatric unit, a NICU, interventional cardiology, or the specialized equipment to perform complex opthalmological procedures such as the surgery to repair retinal detachment); --The types of emergency services that the emergency physicians can provide without the need for a specialty consult or specialty evaluation in the ED because they have the training and experience to provide them, with the assistance of internists/family practitioners, orthopedists, and surgeons who are on call for the ED 24/7, 365 days/year. Such services include, e.g., allergy, dermatology, podiatry, radiation/oncology, hematology/oncology, etc.;	06/18/07 06/18/07 & 07/03/07

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A 459	Continued From page 12B	A 459	--The number of physicians on staff, including the number of active staff specialists who have committed to provide on-call coverage for the ED; --Other demands on these physicians (practice and surgery schedules, participation in medical staff leadership activities, peer review activities, utilization review, vacations, requirements to obtain continuing medical education, etc.); --The frequency with which the Hospital's patients typically require services of certain specialists in the ED; and --The provisions the Hospital has made for situations in which a physician in a particular specialty is not on call or the on-call physician is unable to respond. Such provisions include: * The ability to have a general surgeon, trauma surgeon, orthopedic surgeon, obstetrician, pediatrician, neurosurgeon, family practitioner, internist, or hospitalist admit the patient to render appropriate care, * If a transfer is necessary, having readily available to ED staff a prioritized list of other facilities that are capable of handling various conditions so the ED immediately calls appropriate facilities to seek a transfer, and * Having transfer agreements in place with a number of other facilities to streamline transfer arrangements if those facilities are the appropriate places to send the patient. Hospital Administration and Governing Body members noted that: --CMS recognizes that the Hospital "has the discretion to maintain the on-call list in a manner that best meets the needs of the hospital's patients who are receiving services	06/18/07

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A 459	Continued From page 12C	A 459	required under EMTALA" in accordance with the resources available to the hospital, including the availability of on-call physicians. --While CMS recognizes that it is a best practice that the particular services a hospital offers to the public should be available through on-call coverage of the ED, CMS also recognizes that a hospital is not required to have 24/7 coverage in all specialties, and that implementing such coverage in some specialties (e.g., allergy or certain subspecialties with very few physicians) would detract from the availability of the most needed specialists, such as internists/family practitioners, general surgeons, orthopedists, trauma surgeons, neurosurgeons, pediatricians, OB/gyn specialists, and cardiologists. Administration and ED Physician Leadership reviewed and confirmed there was call coverage for the following specialties, and noted that the citation is mistaken when it says that the Hospital does not have call coverage for neurology and pulmonology, which are provided as follows: --Anesthesiology (on call 24/7, 365 days/year) --Internal Medicine/Family Practice (on call 24/7, 365 days/year) --Pediatrics (on call 24/7, 365 days/year) --OB/Gyn (on call 24/7, 365 days/year) --General Surgery (on call 24/7, 365 days/year) --Orthopedic Surgery (on call 24/7, 365 days/year) --Trauma Surgery (on call 24/7, 365 days/year) --Neurosurgery (on call 24/7 for all but 2-3 days each month) --Cardiology (on call 24/7, 365 days/year) --Neurology (currently on call 24/7 for 7 days a month, with efforts underway to add teleneurology on an expedited basis to provide 24/7 coverage for the rest of each month)	07/02/07

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A 459	Continued From page 12D	A 459	through teleneurology --Pulmonology (24/7 for 7 days a month, and because most pulmonary emergencies involve managing patients on a ventilator, a combination of pulmonologists and internists newly credentialed to managed ventilator patients enables additional on call coverage for ventilator patients 24/7 for 20+ days per month, with a goal of coverage nearly every day) --Vascular Surgery (covered by a specific vascular surgeon when scheduled on Trauma Surgery call panel) Administration and ED Physician Leadership reviewed the specialties not covered by the ED call panel or where there are gaps in coverage, confirmed that it would not be appropriate for some specialties to take call because they do not typically treat emergencies, and therefore identified the appropriate practitioners who provide coverage and who are qualified to assess and provide stabilizing treatment for ED patients with emergencies: --Allergy: ED physicians on site 24/7 for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365 days/year; allergists do not usually handle emergencies --Dentistry: See Oral Surgery; the only dentist on staff practices general dentistry, and any dental emergencies are actually oral surgery issues --Dermatology: ED physicians on site 24/7 for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365 days/year (to the extent a patient may have a dermatological emergency) --Endocrinology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year	07/02/07

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A 459	Continued From page 12E	A 459	--Gastroenterology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Hematology/Oncology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Infectious Diseases: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Nephrology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Neurology (when there is a gap in coverage): ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year, and Neurosurgeons on call 24/7 for all but 2-3 days/month --Ophthalmology: ED physicians on site 24/7 for 365 days/year; the Hospital does not offer complex ophthalmological surgeries because it does not have the necessary specialized equipment --Oral Surgery: ED physicians on site 24/7 for 365 days/year --Pain Management: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Plastic Surgery: ED physicians on site 24/7 for 365 days/year, and General Surgeons on call 24/7 for 365 days/year --Podiatry: ED physicians on site 24/7 for 365 days/year, Orthopedic Surgeons on call 24/7 for 365 days/year	

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A 459	Continued From page 12F	A 459	--Psychiatry: Not a service offered by the Hospital because the Hospital does not have a psychiatric unit --Pulmonology: ED physicians on site 24/7 for 365 days/year, Pulmonologists on call 24/7 for 7 days a month, and Internists credentialed to manage patients on ventilators on call 24/7 for most of the remaining 23-24 days per month --Radiation/Oncology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Rheumatology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Urology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Vascular Surgery: Covered 24/7 for several days a month by a specific vascular surgeon when scheduled on the Trauma Surgery call panel Administration and ED Physician Leadership developed a grid to facilitate provision of care by on-call specialists and, when a transfer is necessary, to streamline the arrangements for transfer. Specifically, the grid guides ED staff in calling the appropriate on-call specialist for ED patients, and in calling the hospitals capable of furnishing the specialty care that the patient needs and that the Hospital cannot provide at that time. SEE EXHIBIT B. Administration and ED Physician Leadership reviewed and revised the ED on-call list so that all pertinent information about what physicians are on call appears on one page. SEE EXHIBIT C.	07/03/07 07/03/07

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A 459	Continued From page 12G	A 459	Administration and the Chair of the PI/RM Committee circulated the grid and revised on-call list to ED staff with a memorandum confirming use of the on-call list and of the grid.	07/03/07
			Administration clarified that ED staff must contact the appropriate specialist listed on the on-call roster when needed to assess/treat a patient with a possible emergency, rather than calling physicians who are NOT on call.	07/03/07
			Administration reviewed and clarified that ED staff should arrange for an appropriate transfer when the appropriate on-call specialist is not available, there is a gap in coverage for the ED, the patient requires services the Hospital does not provide, or the patient needs a higher level of care.	07/03/07
			ED Leadership met with ED staff to discuss the system for using the on-call list and the grid to obtain appropriate emergency care for ED patients in a timely fashion.	07/03/07
			The CEO and COO are negotiating a contract for teleneurology to be available to the ED 24/7 for all days where there is no neurology coverage, with a projected launch of the system by sometime in fall 2007. Through teleneurology, the ED will have the benefit of neurologists reading tests and ordering appropriate treatment for neurological problems that require prompt treatment (such as administration of TPA).	In process
			Administration is negotiating to add interventional cardiology as a Hospital service that would be available to both ED patients and hospital inpatients.	In process
			Administration has initiated the process for adding a NICU, which would be available to both ED patients and hospital inpatients.	Under construction

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A 459	Continued From page 12H	A 459	The Governing Body reviewed and confirmed that the adoption of the voluntary call system did not diminish the availability of emergency services to patients. The Governing Body reviewed the overall rate of transfers out of the ED before and after the implementation of the current call system for the ED. Most significantly, the overall rate of transfers (calculated by dividing the number of transfers by the number of emergency visits for each month) has remained essentially the same, and most of the transfers are done because the patients need services the Hospital does not currently provide (such as psychiatry, interventional cardiology, and NICU services). The Governing Body also reviewed and confirmed that the physicians who elect to participate in taking call for the ED are then obligated to respond to calls from the Hospital: --Once a physician volunteers to participate in call, the on-call physician must respond to the ED at least by telephone within 30 minutes of receiving a call, unless the physician is unable to respond for an appropriate reason (i.e., due to circumstances beyond the physician's control, such as the fact that the on-call physician is in emergency surgery for another patient). --If asked, the on-call physician must come to the ED within 30 minutes and provide care to unassigned patients. --If indicated, during the telephone call, the on-call physician can provide feedback, information, and/or orders to the ED staff to act on while the on-call physician is coming to the ED. For example, when a patient must go to emergency surgery, the Hospital uses the time a surgeon is in transit to the Hospital to gather the OR team and prepare a patient for surgery so there is no delay once the surgeon arrives at the Hospital.	06/18/07 06/18/07

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A 459	Continued From page 12I	A 459	Administration provided reminder training to all RN and Respiratory Care Professional staff on the 30 minute response requirement for physicians, how to run the chain of command, and when to complete an HPRR, as described in A 186.	06/29/07
			The Medical Staff members of the Governing Board drafted and circulated a letter to all Medical Staff members reminding them that they must respond at least by telephone to calls from Hospital staff about their inpatients, and when they are on call for the ED, they must respond by telephone or in person to calls from the ED within 30 minutes, and must come to the ED within 30 minutes when requested. The letter was mailed, faxed, placed in physicians' mailboxes, and posted in all physician areas at both Hospital campuses. SEE EXHIBIT A.	06/21/07
			Administration reviewed and confirmed several transfer agreements that it has with hospitals to facilitate the transfers of patients from the ED when those facilities are the best facilities available to furnish care the Hospital cannot provide. For example, the Hospital has one transfer agreement specifically with a children's hospital for pediatric transfers.	06/25/07
			Administration entered into two additional transfer agreements to facilitate transfers from the ED.	06/25/07
			ED Leadership is responsible for reviewing a random sample for the timely response to page by the ED call panel physician. Please also see description of monitoring for reason and appropriateness of transfers as described earlier in this tag and under A 456, and for additional actions to monitor physicians' response to calls under A 186.	07/03/07 & ongoing
			The COO and/or the PI/RM chair are responsible for reporting the analysis of the monitors to the ED Department, the PI/RM	07/03/07 & ongoing

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A 459	Continued From page 12J	A 459	Committee, the MEC, and (as indicated) the Governing Body to inform those committees in regularly assessing the appropriateness of on-call coverage for the ED. ALLEGATION OF COMPLIANCE WITH A 459: The Hospital nevertheless respectfully disagrees that it violated the acceptable standards of practice with respect to furnishing on-call coverage for the ED. The citations inappropriately expand the rule when they state, "[T]he facility failed to ensure that Emergency Services were provided in a manner that met the needs of the patients in accordance with acceptable standards of practice for the provision of on-call physician coverage to the Emergency Department (ED) for services that the facility offered to the public." But that is not the standard established by the Medicare rules. The CoP on Emergency Services states that hospitals "must meet the emergency needs of patients in accordance with acceptable standards of practice." As noted above, the Interpretive Guidelines further clarify that "acceptable standards of practice" include "maintaining compliance with applicable Federal and State laws, regulations, and guidelines regarding hospital emergency services, as well as any standards or recommendations promoted by or established by nationally recognized professional organizations" such as the AMA, ANA, or ACEP. "Acceptable standards of practice" include the EMTALA rules. Neither the Emergency Services CoP nor EMTALA requires ED call coverage for every service a hospital offers, and the 2567 does not cite any other standards that do.	

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A 459	Continued From page 12K	A 459	In support of the citation, Tag A 459 lists specialties that do not have a call panel, including allergy, dermatology, endocrinology, hematology/oncology, infectious disease, nephrology, podiatry, psychiatry, radiation oncology, rheumatology, and vascular surgery. These examples do not support the finding of a violation: --Many of these listed specialties would never be required to manage an emergency because the ED physicians or more general on-call specialists can handle the emergency. For example, ED physicians regularly treat and stabilize allergic reactions and do not call an allergist. --The Hospital does not offer psychiatric services--it has no psychiatric unit or beds; there is one psychiatrist on staff to provide an occasional consult for an inpatient who has psychiatric problems secondary to the medical issues. --The listing of no vascular surgery call panel indicates the surveyors failed to recognize that one of the two vascular surgeons on staff already participates regularly in the trauma call panel providing emergency coverage for the ED. The Emergency Services CoP further states that there "must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility." This rule likewise does not require 24/7 emergency call coverage for all services offered by the Hospital. CMS recently issued S&C Letter 07-19 on hospital responsibilities for emergency services; that document clarifies that hospitals must "appraise medical emergencies, provide initial treatment and referral when appropriate...." The Hospital meets these requirements:	

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A 459	Continued From page 12L	A 459	--There is a qualified ED physician on duty at all times in the ED; --There is a call roster for the ED so that at any given time the ED knows what specialties are covered, and when physicians are on call for the ED, they MUST respond, come to the ED when requested, and provide care to unassigned patients. --The call roster reflects coverage 24/7, nearly 365 days/year by the major specialties needed by ED patients; these include internal medicine/family practice, pediatrics, general surgery, orthopedic surgery, neurosurgery, and cardiology, among others. --The Hospital furnishes 24/7 nursing services and staffs with nurses trained to handle emergencies. Two patient cases (#119 & 120) are cited in the 2567 are cited to support the allegation that the Hospital failed to meet the emergency needs of its ED patients. However, instead of showing failure to meet the emergency needs of patients, these cases demonstrate how the Hospital successfully meets the emergency needs of its patients as required under the CoPs. Citing these cases seems to send the message that no patients should EVER be transferred, when the rules clearly permit appropriate transfers and encourage them when they are necessary to assure patients receive the care they need. The 2567 cites patient #120 as an example of a transfer (a) necessitated because there was not an ophthalmologist on call, and (b) done nearly eight hours after the patient's arrival in the ED. An analysis of the record confirmed that neither conclusion is correct.	

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A 459	Continued From page 12M	A 459	--The patient would have been transferred even if an ophthalmologist had been available. Because the patient had a possible retinal detachment that could require a complex surgical procedure, and because the Hospital does not have the specialized equipment to do those procedures, the patient was transferred to a tertiary care facility that performs a large number of those procedures. --Additionally, the 2567 states that this patient was transferred at 0743 on April 3, 2007; the medical record documents, however, that the patient left the ED at 0336, about 3 ½ hours after arriving at the ED. Because the patient reported hitting his head, the ED physician had CT scans done of the head and orbits to confirm there were no fractures before arranging a prompt transfer to the tertiary care facility to treat the possible retinal detachment definitively. A review of the medical record of patient #119 also indicates the Hospital met the patient's emergency needs: --Although the patient came in at 1010 on March 27, 2007 having seizures and was diagnosed with Status Epilepticus, the Hospital provided medication so that the last documented seizure occurred at 1224, and the patient was alert and interacting by 1354. --The patient was transferred in a stabilized, nonemergent condition at 1623 to a facility with neurologists available to do a complete workup and address ongoing treatment. The patient was no longer having seizures, and the ambulance transporting the patient had a critical care nurse on board merely as a precaution.	

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A 459	Continued From page 12N	A 459	Finally, the Hospital provided the surveyors with several lists of charts they could access on the Hospital's document imaging system. These included a list of 140 active inpatients, an OR log of 4,200 cases from the past six months, an ER log of 18,000 visits over a three month period, and an additional 163 cases responding to specific categories requested. Out of numerous cases the surveyors assumedly reviewed, the 2567 documents an IJ on the basis of three records, none of which reflects a bad outcome and, as described above, all of which indicate the Hospital is meeting the emergency needs of patients. The conclusion that there is an IJ at the Hospital is not supported by the cited evidence. For these reasons, the Hospital submits that there was no immediate jeopardy to patients at the time of the survey, nor is there now; that the Hospital was and is in compliance with the rules; that this citation should be removed; and that the entire 2567 should be withdrawn.	

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A 185	Continued From page 99 having specialists on call for the ED was discussed "regularly" in the ED committee meetings, and PI was not involved because "we already knew we had a problem". The Medical Director of the ED (also a member of the Board of Directors) was interviewed on May 31, 2007, at 1:20 PM. He stated that the voluntary call system was "inconvenient" and that often patients were transferred for the lack of an available specialist. He stated that "It's a problem" and that he had empathy for the patients. He stated the primary issue was customer satisfaction. He stated that although many specialties did not have a physician on-call, Urology was the most common specialty to have nobody who would come in to see a patient. He stated the problem with ventilated patients had improved since Physician D joined the pulmonary/intensive care team. However, Physician D was only on-call one week every four weeks. He stated that the ED physicians were "working with what we have to work with." He further stated that no Quality Assurance/Performance Improvement (QAPI) activities were being done to determine the effect the voluntary call system had on patient care, transfers or time spent trying to find a consultant. The Medical Director stated that he spoke at one of the Medical Executive Committee (MEC) meetings, and he told the committee about the difficulty dealing with the voluntary call system; "but until you are in my shoes, looking into the patient's eyes, you cannot know how we (the ED physicians) feel." Physician E was the prior ED director, and sat on both the Medical Executive Committee (MEC) and the hospital board. He was interviewed on	A 185	In support of this position, for example, Tag A 459 lists specialties that do not have a call panel, including allergy, dermatology, endocrinology, hematology/oncology, infectious disease, nephrology, podiatry, psychiatry, radiation oncology, rheumatology, and vascular surgery. These examples do not support the finding of a violation for the following reasons: --Many of these listed specialties would never be required to manage an emergency because the ED physicians or more general on-call specialists can handle the emergency. For example, ED physicians regularly treat and stabilize allergic reactions and do not call an allergist. --The Hospital does not offer psychiatric services--it has no psychiatric unit or beds; there is one psychiatrist on staff to provide an occasional consult for an inpatient who has psychiatric problems secondary to the medical issues. --The listing of no vascular surgery call panel indicates the surveyors failed to recognize that one of the two vascular surgeons on staff already participates regularly in the trauma call panel providing emergency coverage for the ED. The Emergency Services CoP further states that there "must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs	

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A 185	Continued From page 100 May 31, 2007, at 2:30 PM. Physician E stated that he was taking the Chief of Staffs (COS) place in the interview, since she was not available. He stated he had "no perception" of any Quality Assurance/Performance Improvement (QAPI) activities relating to the effects of the institution of voluntary call for specialties on patient care either in the ED or ICU. He stated that the MEC in general seemed to be a "mixed bag" when it came to the voluntary call. The committee had to balance pro patient care sentiment with pro voluntary call sentiment. He mentioned that there were three staff physicians on the board. He described how the MEC informed the COS that there would be no patient safety issues with voluntary call. The COS, in her reports to the Board, tried to use this information to convince the Board to approve the change in bylaws to allow for voluntary call panels. The COS was not available for comment. Physician E further stated that at the Board retreat in November, 2006, further discussion about voluntary call occurred, at which time the COS continued to push for the change. Findings at RSMC: During a review of ICU medical records on June 1, 2007, the following was noted: Patient 44, a 91 year old male, was admitted to the ICU on May 31, 2007, on a ventilator (breathing machine). On June 1, 2007, at 6 AM, the ICU nurse paged Pulmonologist #1, who had done the initial pulmonary consult for ventilator management, to report blood gas results (to show how well the ventilator is assisting the lungs). There was no response, so the ICU nurse repaged Pulmonologist #1 at 6:20 AM. At 6:30	A 185	anticipated by the facility." This rule likewise does not require 24/7 emergency call coverage for all services offered by the Hospital. CMS recently issued S&C Letter 07-19 on hospital responsibilities for emergency services; that document clarifies that hospitals must "appraise medical emergencies, provide initial treatment and referral when appropriate...." The Hospital meets these requirements as follows: --There is a qualified ED physician on duty at all times in the ED at each hospital campus; --There is a call roster for the ED so that at any given time the ED knows what specialties are covered, and when physicians are on call for the ED, they MUST respond, come to the ED when requested, and provide care to unassigned patients. --The call roster reflects coverage 24/7, nearly 365 days/year by the major specialties needed by ED patients; these include internal medicine/family practice, pediatrics, general surgery, orthopedic surgery, neurosurgery, and cardiology, among others. --The Hospital furnishes 24/7 nursing services and staffs with nurses trained to handle emergencies.	

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A 185	Continued From page 101 AM, Pulmonologist #1 called back and said he was not on call, but Pulmonologist #2 was. At 6:35 AM, the ICU nurse paged Pulmonologist #2. At 6:45 AM, there was no response from Pulmonologist #2, so the nurse paged again. At 6:45 AM, there was still no response from Pulmonologist #2, so the ICU nurse paged the house supervisor for assistance. At 6:50 AM, Pulmonologist #2 returned his page to the ICU nurse. During an interview with ICU RN 4 on June 1, 2007, at 11:50 AM, the nurse stated that the pulmonology service had been a problem when they were trying to get somebody to manage the patient on a ventilator, but their biggest problem was with neurology. She stated that the neurologists did not have to be on call, and MD 3 told them that he did not have to take call, so if he did not want to come in, he did not have to. ICU RN 4 stated that the ICU nurses made multiple phone calls, and spent hours of their days on the telephone trying to get in touch with doctors. Physician B, a neurologist who provided services at both hospitals, was interviewed on June 1, 2007 at 1:55 PM, by telephone. He stated that there were four neurologists on staff, and that they went to a voluntary call schedule because the call was causing "burn out" among the physicians. Physician B stated the ED physicians were "pathological dumpers" who didn't want to work-up the patients in the ED. He emphasized that the hospital was not supporting them. He also stated that the administration had arranged call coverage with a new contracted neurologist, but that she was unavailable to come to the facility when she was supposed to be on call, stating that she was not on call, or in Los	A 185	Several cases are cited in the 2567 to support the allegation that the Hospital failed to meet the emergency needs of its ED patients. However, instead of showing failure to meet the emergency needs of patients, these cases demonstrate how the Hospital successfully meets the emergency needs of its patients as required under the CoPs. Citing these cases seems to send the message that no patients should EVER be transferred, when the rules clearly permit appropriate transfers and encourage them when they are necessary to assure patients receive the care they need. Patient #36: The record indicates that the patient received an appropriate medical screening examination, and it was determined that the patient had problems with an indwelling catheter, a procedure that had been performed at the VA hospital. The patient had a long history of treatment at the VA hospital for urological problems. The ED physician consulted with a urologist by phone and was able to evaluate and stabilize the patient. The patient was then transferred to the VA Hospital where the patient had undergone the procedure with an indwelling catheter; the transfer was appropriate for continuity of care. Patient #40: The record indicates that this 40-year-old man had a peritonsillar abscess. There was no ENT physician on call at the time. The ED physician attempted to make arrangements for transfer to a hospital with an ENT on call, which was appropriate and reasonable.	

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A 185	Continued From page 102 Angeles. Physician B recommended the survey team review the chart of Patient 201. Reportedly, Patient 201 was an inpatient in the ICU at IVMC. The neurologist involved in the case told the admitting physician that he would be out of town. When a neurologist was urgently needed, the contracted physician was contacted, but was unable or unwilling to come to the facility to provide consultative services for Patient 201. During an interview with ICU RN 5 on June 1, 2007, at 2:43 PM, she stated that she wrote a verbal order for a neurology consult that morning for MD 4 to do. She stated she called MD 4, and was told that MD 5 was on call for neurology, so to call that physician instead. ICU RN 5 called MD 5, and was told that MD 3 was on call for neurology, so call that physician instead. ICU RN 5 stated that if she needed to know who was on call for a specialty, she called the offices and asks if they knew. When she was asked who was on call for neurology that day (June 1, 2007), she answered, "I guess it's MD 3". ICU RN 5 stated that she did not have a call list, but she could call the ED to see who was on call. When she was asked if she was aware that there was nobody on call for neurology for the ED, she stated, "no". In the ICU on June 1, 2007, at 2:52 PM, in the presence of four ICU nurses and three ICU managers, a general question was asked of them, how much time do you spend making calls to try to find physicians? They all answered, "a lot". Physician G, an Internal Medicine doctor serving both hospitals, was interviewed on June 1, 2007 at 3:25 PM at RSMC. He stated that there had	A 185	Patient #105: On March 2, 2007, this patient was sent to the ED by her primary physician for evaluation of possible stroke and was found to have a bleed. The ED physician was able to talk to one of the neurosurgeons on staff regarding options for the patient, but the neurosurgeon was not on call and was out of town that day. It was nevertheless helpful to the ED physician to consult with the neurosurgeon even though the patient needed to be transferred. The ED physician was able to address any emergent needs the patient had and transferred the patient in a stabilized condition to another hospital. Additionally, the hospital implemented nearly 24/7 call coverage for neurosurgery by March 8, 2007, just after this case occurred. Therefore, the hospital appropriately transferred this patient, and then improved the call coverage for neurosurgery well before the survey. Patient #118: This patient was evaluated in the ED for a fracture of his left leg. While there was an orthopedic surgeon on call for the ED that day, the patient requested that the ED physician contact the patient's primary care physician about the case. The patient's primary care physician requested that the patient be transferred to the hospital where the primary care physician had privileges and where the patient could continue to be followed by his regular treating orthopedist. After the ED physician stabilized the patient's fracture, he transferred the patient as requested.	

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A 185	Continued From page 103 been a "couple of instances" when he had a patient who needed a Neurology consult and was unable to obtain one. He also said that he generally called Physician F when he needed a pulmonology/critical care consult, bypassing the on-call schedule, because he got a better response. He added that "In general, it is not easy to get consultations at this hospital." He also stated that there was poor communication between doctors and administration. During a review of ED medical records on June 1, 2007, the following was noted: a. Patient 31, an 84 year old male, presented to the ED on April 20, 2007, at 5:57 PM, with a chief complaint of a syncopal (dizzy) episode and a fall. The triage assessment, completed on April 20, 2007, at 6:06 PM, showed that Patient 31 had a hematoma (blood pocket under the skin) above the left eye and on the left forehead, and had a headache. The nurse's notes showed that the patients headache continued throughout the ED stay, and he was medicated on five different occasions for the pain. The ED physician dictated report showed that Patient 31 had a Computerized Tomography (CT) scan of his head, that showed a subdural hematoma (bleeding in the brain) on the right side. The ED physician noted that the facility neurosurgeon was not on call that day, and "he (Patient 31) will be transferred for a higher level of care, we do not have a neurosurgeon on call at this time". Patient 31 was transferred to another facility at 9 PM, with a blood pressure of 195/66, accompanied by a critical care transport team, for a "higher level of care". A review of the Medical Staff Roster on May 31,	A 185	Patient #119: A review of the medical record of patient #119 indicates the Hospital met the patient's emergency needs as follows: --Although the patient came in at 1010 on March 27, 2007 having seizures and was diagnosed with Status Epilepticus, the Hospital provided medication so that the LAST documented seizure occurred at 1224, and the patient was alert and interacting by 1354. The transfer did not occur for another 6 hours. --The patient was transferred in a stabilized, nonemergent condition at 1623 to a facility with neurologists available to do a complete workup and address ongoing treatment. The patient was no longer having seizures, and the ambulance transporting the patient had a critical care nurse on board merely as a precaution. Patient #120: The 2567 cites patient #120 as an example of a transfer (a) necessitated because there was not an ophthalmologist on call, and (b) done nearly eight hours after the patient's arrival in the ED. An analysis of the record confirmed that neither conclusion is correct. --The patient would have been transferred even if an ophthalmologist had been available. Because the patient had a possible retinal detachment that could require a complex surgical procedure, and because the Hospital does not have the specialized equipment to do those procedures, the patient was transferred to	

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A 185	Continued From page 104 2007, showed that the facility had two neurosurgeons on active staff, and only one neurosurgeon was serving on the ED backup call schedule. A review of the April 2007 Emergency Department On-Call Schedule on May 31, 2007, showed that there was a neurosurgeon scheduled to be on call on April 20, 2007. b. Patient 36, a 60 year old male, presented to the ED on April 4, 2007, at 3:47 AM, with a chief complaint of abdominal pain. The ED physician dictated report showed that the patient had a kidney stone on the right side, and needed to be seen by a urologist. The ED physician contacted a urologist on staff at the facility, who did not come in to see Patient 36. Patient 36 was transferred to another facility at 8:50 AM, for urology care. A review of the Medical Staff Roster on May 31, 2007, showed that the facility had six urologists on active staff. A review of the ED on-call schedule on June 1, 2007, showed the urology service ED call listed as "voluntary". c. Patient 40, a 43 year old male, presented to the ED on April 23, 2007, at 10:28 AM, with a chief complaint of sore throat. The ED physician dictated report showed that Patient 40 had a peritonsillar abscess (an abscess around the tonsils), and was having difficulty swallowing. The ED physician noted that he, "discussed transferring the patient for ENT (Ear, Nose and Throat) services, as we have no ear/nose/throat specialist on call today". Patient 40 was	A 185	a tertiary care facility that performs a large number of those procedures. --Additionally, the 2567 states that this patient was transferred at 0743 on April 3, 2007; the medical record documents, however, that the patient left the ED at 0336, about 3 ½ hours after arriving at the ED. Because the patient reported hitting his head, the ED physician had CT scans done of the head and orbits to confirm there were no fractures before arranging a prompt transfer to the tertiary care facility to treat the possible retinal detachment definitively. Patient #121: This patient was evaluated in the ED, where the ED staff found no evidence of GI bleeding after inserting a nasogastric tube and having an abdominal CT done. The patient was offered admission but refused and requested transfer to another hospital. This request was honored, and the patient was transferred. Patient #122: This patient came to the ED needing further examination and treatment by an ophtalmologist. Because there was not an opthalmologist on call for the ED, the patient was appropriate stabilized and transferred to another hospital. Patient #124: This patient was evaluated in the ED and required inpatient admission related to acute renal failure and anemia. However, the patient required care in a pediatric ICU, which the Hospital does not have. Arrangements were made	

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SOUTHWEST HEALTHCARE SYSTEM	25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562

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A 185	Continued From page 105 transferred to another facility at 12 PM for a "higher level of care for ENT services". A review of the Medical Staff Roster on May 31, 2007, showed that the facility had three ENT physicians on active staff. A review of the ED on-call schedule on June 1, 2007, showed the ENT service was not listed on the call schedule, either as voluntary or mandatory. d. Patient 203, an elderly female, presented to the ED on May 21, 2007, by ambulance, with a complaint of abdominal pain. The patient had a Computerized Tomography (CT) scan of the abdomen, which was normal. A repeat CT with contrast (used to enhance the image) showed gastritis (inflammation of the stomach). The final diagnoses were Elevated Digoxin Level (a medication used to stimulate a failing heart) and Acute Gastritis. The patient was transferred to another facility for treatment. No documentation was present regarding the reason for transfer. Both of the transfer diagnoses were common medical conditions, usually treated by a cardiologist and a gastroenterologist. Both services were offered at this hospital, however the Gastroenterologists were on a voluntary call schedule for ED back up. e. Patient 204, an elderly female, presented to the ED on May 21, 2007. The physician's notes indicated that she was to be admitted to the telemetry unit with a diagnosis of Cerebral Vascular Accident (CVA, stroke). The nurses notes also stated "Admit to telemetry". Patient 204 was instead transferred to another facility. No documentation was present regarding why the	A 185	to transfer the patient to a Hospital with a Pediatric ICU that could provide the services required by the patient. Patient #203: This patient was evaluated for abdominal pain; the first CT scan came back negative, and the second CT scan indicated gastritis. This patient was transferred to another hospital because her primary physician was not on staff at the Hospital. The ED made sure the patient was not in an emergent state, and then transferred her in a stable condition to a hospital where her physician had privileges. Patient # 204: The report incorrectly reports what occurred with this patient. This patient was not transferred. She was admitted to the Hospital. After discussions concerning possible nursing home placement, the patient chose to be discharged home, and the discharge took place the day after admission. Patient #205: This patient was appropriately evaluated in the ED. The patient needed plastic surgery to repair a laceration to his eyelid. However, there were no plastic surgeons on call at the time he presented. The Hospital made arrangements for an appropriate transfer to another hospital that had plastic surgery capability. Patient # 206: An ambulance brought this patient to the ED with possible CVA. The patient was appropriately evaluated. and it was determined that the patient needed to be admitted. Because the	

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A 185	Continued From page 106 admission was changed to a transfer. A CVA was a common neurological condition, usually treated by a neurologist. The hospital provided neurology services, but the neurology service had a voluntary call schedule for ED back up. f. Patient 205, a young man, presented to the ED on May 5, 2007, with a chief complaint of an eye injury. The ED physician noted that there was a laceration to the upper eyelid that would require the services of a plastic surgeon, a specialty service that is offered at this hospital. However, plastic surgery physicians are on a voluntary call schedule. The patient was transferred to another facility for care. g. Patient 206, a female patient, presented to the ED on May 29, 2007, via paramedics, with a chief complaint of inability to speak and right sided weakness. The ED physician's notes indicated the patient had a probable CVA. This was a common neurological condition usually handled by a neurologist, a service offered at this hospital. Patient 206 was transferred to another facility. The ED physician's notes stated, "We do not have neurology on call." During an interview with the ED Unit Secretary (US) on June 1, 2007, at 10:40 AM, the US stated that when she needed to call a specialty physician, she asked the ED physician or the patient's primary care physician (PCP) which specialist they wanted her to call. She then called that specialist and asked them if they would "consider" taking care of the patient. If the specialist declined, she asked the ED physician or the PCP who to call next, and she continued until she found a specialist that was "willing" to take care of the patient. The US stated that she	A 185	patient's primary care physician had privileges at another hospital, the patient requested transfer to that hospital. The patient was transferred after being stabilized. For these reasons, the Hospital submits that the Hospital was and is in compliance with the rules; that this citation should be removed; and that the entire 2567 should be withdrawn.	

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A 185	Continued From page 107 was "usually" able to find somebody to come in. She stated that if they were unable to find a specialist, then the patient got transferred to another facility, but "that doesn't happen very often". During an interview with ED Physician 2 on June 1, 2007, at 11:13 AM, he stated that the voluntary call system "made the job more difficult". ED Physician 2 stated that he had been using the Internal Medicine (IM) or Family Practice (FP) physician for advice on what specialist to call. He stated that it took longer to get a specialist now that it was voluntary, and he had to make multiple calls, but he could usually get somebody to come in.	A 185		
A 186	482.22(c) MEDICAL STAFF BYLAWS The medical staff must adopt and enforce bylaws to carry out its responsibilities. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the medical staff enforced their bylaws/rules and regulations in regard to physician on-call coverage by specialists with active and provisional privileges at the facility, for 11 of 62 patients at IVMC (Patient 135, 201, 202, 105, 118, 119, 120, 121, 122, 124 and 129), and eight of 70 patients at RSMC (Patient 44, 31, 36, 40, 203, 204, 205 and 206). Findings at IVMC: On May 30, 2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated the	A 186	This tag quotes provisions from the Medical Staff Bylaws and Rules and Regulations, while mixing up those that apply on the inpatient side and those that apply to ED call coverage. Likewise, the examples cited are a mix of examples of inpatients and ED patients, and physician responsibilities differ depending on whether the patient is admitted or in the ED. The Bylaws and Rules and Regulations state clearly that physicians who admit patients to the hospital are responsible for responding promptly to calls about their patients or arranging for coverage when they are unavailable. With respect to the ED, although physicians have discretion about volunteering to participate on the ED call list, once they agree to take call for the ED, they must respond and come in when requested.	

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A 186	Continued From page 108 practice for the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the Governing Body initially approved the voluntary call system on a trial basis for 90 days, and subsequently extended the trial time on two separate occasions. The current on-call physician coverage for the facility was voluntary. The meeting minutes for the Family Practice Department were reviewed on May 30, 2007. In the minutes dated November 29, 2006, there was a report by Emergency Department (ED) Physician B for ED Physician C, that advised, "Since call is currently voluntary, written agreements are currently in progress by administration for specialists. We currently do not have a formal call panel for Neurology, ENT, Pulmonology, and Ophthalmology, causing patients to be transferred. The minutes for March 2007, were also reviewed. In the first paragraph of the executive session was the statement, "The department noted that neurosurgeons have the choice to respond or not to a consult request." On May 30, 2007, the Medical Staff Bylaws, that were revised on February 22, 2007, were reviewed. The Bylaws specified, "Each active medical staff member shall...Actively participate on, and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including but not limited to emergency services and back-up functions....Provisional staff members seeking Active staff membership shall participate in emergency services and back-up functions." On May 30, 2007, a review of the current Medical Staff Rules and Regulations, that were revised	A 186	Administration reviewed and confirmed that the Bylaws and Rules and Regulations had been revised and approved in February 2007. Administration reviewed and identified several provisions, such as Rule section 2.1.1, that retained some language about ED coverage being an obligation of all medical staff members. The Governing Body reviewed section 2.1.1 and clarified how such a provision should be interpreted in light of the decision to make participation on the ED call list voluntary. The Governing Body forwarded the interpretation to the Medical Executive Committee (MEC) for review and consideration of revision when the Rules and Regulations are next amended. The Governing Body issued a letter to all Medical Staff members emphasizing the interpretation of Rule section 2.1.1. that participation on the ED call panel may be voluntary, but that any physician serving on the call panel is obligated to respond. The Governing Body reviewed the CMS Conditions of Participation requirements, Interpretive Guidelines, and survey procedures concerning Medical Staff Bylaws. The Hospital Governing Body and MEC leadership reviewed and confirmed that physicians who admit their patients to the Hospital must be available to provide care for their patients in a timely manner or arrange for an alternate practitioner who has equivalent clinical privileges at the	07/13/07 07/13/07 07/16/07 08/03/07 06/18/07 06/18/07

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A 186	Continued From page 109 May 22, 2006, showed that: a. Section 1.3.2; "Each practitioner must be available to provide professional care for his/her patients in a timely manner (30 minutes) or arrange for an alternate practitioner who has equivalent clinical privileges at the hospital." b. Section 2.1.1; "A call panel has been established for referring patients who need hospital care to qualified medical staff members. Service on the call panel is not a privilege, but is an obligation of staff membership." c. Section 2.2.1; "Practitioners on call must respond promptly when requested to see a patient. Practitioners, including specialty consultants, must respond initially by phone or in person within approximately 30 minutes of the time the request to respond is made." d. Section 2.2.3; "When scheduled on call, each practitioner shall accept the care of all patients who are appropriately referred..." e. Section 2.2.4; "The on call specialist must also be available for inpatients. If no other specialist in that specialty is willing or able to provide care for a particular inpatient, the on call specialist has the obligation to see that patient to treat, stabilize or appropriately transfer the patient in a timely manner." f. Section 2.2.7; "A patient will be admitted in the name of the call panel practitioner. The call panel practitioner must be notified about each admission to his service prior to the patient leaving the Emergency Department, and following a discussion with the Emergency Department	A 186	Hospital. The Hospital Governing Body and MEC leadership reviewed and confirmed that participation on the call panel for the ED is not mandatory at this time, but that when a physician agrees to participate on the call panel and is on call for the ED, the physician MUST respond to the Hospital timely when called, MUST come to the Hospital timely to render care when requested, and MUST see all unassigned patients as requested. The Hospital Governing Body and MEC reviewed and confirmed the Medical Staff Bylaws provisions regarding the timeframe for responding to calls from the Hospital regarding the emergency needs of patients (both inpatients and ED patients): --Physicians with admitted patients must respond timely (within 30 minutes) or arrange for another comparable physician to take call and respond timely, AND --Physicians on call for the ED must respond by phone or in person within 30 minutes, and must come to the Hospital within 30 minutes to render care when asked to do so. When the on-call physician has responded first by telephone, he/she can give direction/orders for testing or interventions (as appropriate) while the physician is traveling to the Hospital. The Medical Staff members of the Governing Board drafted and circulated a letter to all Medical Staff members	06/18/07 06/18/07 06/21/07

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A 186	Continued From page 110 physician." The medical record for Patient 135 was reviewed on May 30, 2007. Patient 135, a 66 year old male, was admitted to the Intensive Care Unit (ICU) on May 29, 2007, after an emergency tracheostomy (a tube into the trachea for breathing) was performed in the ED. On the "I.C.U./P.C.U. Flow Sheet", dated May 29, 2007, at 9:30 PM, the nurse documented that Patient 135 became agitated and was fighting the ventilator (breathing machine). The nurse also documented that the patient's attending physician and the pulmonologist were paged for assistance and there was no return call from either physician. During an interview with ICU RN 1 on May 30, 2007, at 9:50 AM, she stated that the pulmonologists took call for their own patients during the week, and the on-call pulmonologist covered on the weekends. When she was asked what they did when there was no pulmonologist on call due to the "voluntary" call system, she stated that they called the ED to see if there was somebody on call, and if not, they called all of the pulmonologists on staff until they found one that was available to help them. During an interview with the Chief Nursing Executive (CNE) on May 30, 2007, at 11:50 AM, the CNE stated that she received complaints from the nursing staff about the physicians not being available when the nurses called them. The CNE said the complaints were becoming "slightly more" in the ED, and "noticeably more" in the ICU. The CNE stated that there was no particular day of the week, time of day, or specialty that was complained about more. She stated it seemed to be more of an "individual person problem." The	A 186	reminding them that they must respond at least by telephone to calls from Hospital staff about their inpatients, and when they are on call for the ED, they must respond by telephone or in person to calls from the ED within 30 minutes, and must come to the ED within 30 minutes when requested. The letter was mailed, faxed, placed in physicians' mailboxes, and posted in all physician areas at both Hospital campuses. The Governing Body approved the recommendations of the Department of Medicine and of the MEC to grant the requests of several internal medicine physicians for additional privileges to manage ventilator patients. As part of this recommendation and approval process, the Department of Medicine, the MEC, and the Governing Body reviewed the categories of physicians allowed to hold ventilator management privileges at multiple hospitals in the surrounding areas. Additionally, these groups recognized that privileges were appropriate for physicians whose scope of practice encompasses this area of patient care management, and that ventilator management is by far the most common emergent need associated with pulmonary care. --These physicians had demonstrated competency and submitted their requests for additional privileges before the survey took place. --The granting of these additional	06/18/07

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A 186	Continued From page 111 CNE declined to give names of the physicians the nursing staff complained about. Further review of the Medical Staff Bylaws (revised 5/22/06) on May 30, 2007, at 3:15 PM. showed that: a. Section 3.7; "Each member of the medical staff shall retain responsibility, within his or her area of professional competence, for the continuous care and supervision of each patient in the hospital for whom he or she is providing services, or arrange for a suitable alternative to assure such care and supervision." b. Section 4.2.3; "Each active Medical Staff Member shall actively participate on and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including, but not limited to emergency services and back-up functions ... c. Section 10.5.3; "A supervisory (departmental) committee shall conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department." d. Section 10.8.5; The duties of department chairs include, "Generally monitor the quality and appropriateness of patient care and professional performance provided by members with clinical privileges in the department ...and oversee the effective conduct of patient care, evaluation, and	A 186	privileges increased the pool of consultants available to provide assistance with ventilator management, to take call in this area and to be available to Hospital Administration and Medical Staff leadership if nursing staff invokes the chain of command to address a patient's sudden change in condition. Administration and ED Physician Leadership revised the on-call roster for the ED so that a pulmonologist or internist privileged to manage patients on ventilators was on call almost 24/7 for the next month, with the goal of providing ventilator management coverage 24/7, 365 days a year going forward. Administration reviewed and confirmed the Hospital has an effective process for obtaining timely assistance from physicians for inpatients with emergency needs: --As has long been the standard of practice, attending physicians direct the care of their patients and are responsible for obtaining consults by specialists, as they deem necessary, and for arranging coverage for themselves when they are not available. If an inpatient has an emergency, the nursing staff first calls the attending physician or the physician covering for the attending. --Other physicians already consulting on the patient's treatment team are likewise obligated to respond if called and to provide coverage for themselves.	07/03/07 06/18/07

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A 186	Continued From page 112 monitoring functions delegated to the department by the Medical Executive Committee," and also, "enforce Medical Staff Bylaws, Rules and Regulations and policies within the department ..." and, "provide for continuous assessment and improvement of the quality of care and services provided." The Performance Improvement Committee shall, "establish systems to identify potential problems in patient care and general areas of potential risk in clinical aspects of patient care and safety." Further review of ICU medical records on May 30, May 31 and June 1, 2007, at IVMC, showed the following: a. Patient 201, a 76-year-old male was admitted to the ICU on May 24, 2007, with a preliminary diagnosis of Epidural Abscess (collection of pus near the spinal cord). A neurology consultation, dated May 24, 2007, was handwritten in the physician's progress notes. A transcribed, dictated and very detailed neurology consultation was in the medical record, also dated May 24, 2007. The transcribed consultation note was identified as being performed by Physician A. At the end of the dictated consultation, Physician A noted that he would be going out of town, and had notified the admitting physician. b. Patient 202, an elderly gentleman with left-sided weakness and pneumonia was hospitalized in ICU at IVMC during the time of survey. On May 31, 2007, at 8:15 AM, Patient 202 suffered a deterioration of his respiratory status. The nurses notes contained the timeline of events. Physician H, a neurologist, was at the bedside of Patient 202 when the nurses called Physician F, a Pulmonologist/Intensivist, also	A 186	--As a backup in an emergency, there is an ED physician in-house at each hospital, 24/7, 365 days a year. --As further backup, if there is a need for a specialist not already consulting on the case, the nursing staff may contact the appropriate physician on the on-call panel for the ED if one is on the schedule, because as the 2567 notes, section 2.2.4 of the Medical Staff Rules states that assisting with inpatient emergencies is a requirement for any physician while on call for the ED. --Because there may be occasions when there is not on-call coverage for the ED in the desired specialty, there is a need for a specialty consultant to address an emergency, and the attending physician has not found a consultant, the nursing staff can run the chain of command to get medical staff assistance with finding a consultant. --As a final and rare option, the Hospital may arrange to transfer the patient to another facility that can address the patient's problem. Administration reviewed and confirmed the Hospital has an effective process for enforcing these requirements. The chain of command assists the nursing staff in responding to the needs of patients, and the reporting and monitoring system is the tool for enforcing the Bylaws provision as follows: --When a physician does not respond	06/18/07

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A 186	Continued From page 113 Medical Director for Respiratory Services, for assistance with an emergency intubation (placement of a breathing tube into the lungs). According to the nurses notes, Physician F was unavailable to come to the hospital. The nurses then paged Physician I to assist with an emergency intubation. Physician I is also a Pulmonary/Critical Care specialist, although he was not listed on the on-call schedule. The nurses informed Physician I that the patient required emergency intubation, but he was unavailable to come to the hospital at that time. A code blue (patient needing resuscitation team) was called and physician J, an ED physician, responded and intubated the patient at approximately 9:05 AM, 50 minutes after the patient was identified to be in severe respiratory distress requiring mechanical ventilation (breathing machine). During an interview with the Director of ICU on May 31, 2007, at 10:20 AM, she stated that she got feedback, from the nurses, for all of the problems that arose in the ICU. According to the Director, the ICU nurses were having a great deal of difficulty getting a pulmonologist to assist with ventilator management up until approximately two months ago. The Director stated with the addition of a new pulmonologist, the problem had improved. She stated she received approximately two calls per month from the ICU nursing staff related to this problem. She stated that when the ICU staff needed to know who was on call for a specialty, they usually knew by "word of mouth." If not, they called the ED for information. If the ED could not help, they called the offices for that particular specialty and inquired. If the offices didn't know, they went "down the list" and called all of the physicians in	A 186	timely to a page and the nurses have to run the chain of command as necessary to meet an urgent patient care need, they are supposed to generate a Healthcare Peer Review Report (HPRR). --The information in the HPRR goes to the physician's Department Chair to address with the physician informally. --The information in the HPRR is also kept for tracking purposes and for consideration during the physician's recredentialing process. --If a physician shows a trend of slow response to pages, then the Hospital holds a formal meeting with the physician to discuss the problem and corrective action, and the physician is monitored after that for a period of time to be sure there are no further delays in responding to pages. Department Managers/Directors reviewed with nursing staff members and Respiratory Care Professionals the process for running the chain of command and generating an HPRR when a physician does not respond timely to an emergency. Administration confirmed that training on the chain of command is also included in each annual competency update that all staff members complete. The Risk Management Department is responsible for monitoring HPRRs to determine whether any physician shows a trend of delay in response to calls from the	06/29/07 06/29/07 06/29/07 & ongoing

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A 186	Continued From page 114 that specialty to see if they could get assistance. If they were still unable to get a specialist, they called the ICU Medical Director. The ICU Director stated that when the nursing staff had a delay in getting a response from a physician, they were supposed to write an HPRR (Healthcare Peer Review Report), that was reviewed and investigated by the clinical lead, and forwarded to the Performance Improvement Department. The ICU staff meeting minutes, dated April 19, 2007, were reviewed on May 31, 2007, at 10:50 AM. Under Department Issues, there was a discussion regarding "nurse apathy". The first causative factor of nurse apathy was listed as "MD's do not seem to have accountability, do not answer pages, pass the buck, change phone numbers constantly". During an interview with ICU RN 2 on May 31, 2007, at 11:05 AM, ICU RN 2 stated that she remembered the April 19 staff meeting when the physician accountability was discussed. ICU RN 2 stated that if they need a specialist, they usually "just know who to call". If they did not know, ICU RN 2 stated, "we sometimes have to call all of the doctors on the list for that specialty". She stated that the problem had not improved yet. During an interview with ICU RN 3 on May 31, 2007, at 11:15 AM, ICU RN 3 stated that she remembered the April 19 staff meeting where the physician accountability was discussed. ICU RN 3 stated that the problem was worse for the night shift, and on the weekends. She stated that the nurses got tired and frustrated, and "we just want to take care of our patients, and the doctors don't care". ICU RN 3 stated that she had completed HPRR's regarding her inability to reach the	A 186	Hospital. Risk Management reports to the PI/RM Committee, which reports as appropriate to the MEC and Governing Body. The Department of Medicine met and discussed methods for making it more efficient for nursing staff to reach the physicians with calls about inpatients. The Chair of the Department of Medicine is responsible for notifying all members of the Department about how to make it easier for the Hospital nursing staff to reach them when calling about inpatients under their care. The CNE is responsible for updating the intranet phone list that nurses use to contact physicians so that the list reflects the changes the physicians are making to enable nursing staff to reach them more quickly and easily. The CNE provided reminder education to nursing staff, and particularly to ICU nursing staff, about calling codes promptly what a patient becomes emergent. Please see tag A 459 for actions the Hospital has taken specifically with respect to emergency call coverage for the ED.	08/01/07 08/31/07 09/15/07 08/30/07

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A 186	Continued From page 115 physicians. The Director of Respiratory Services was interviewed on May 31, 2007 at 3:25 PM. He stated that in the event a patient on a ventilator needed a change in the machine settings, the pulmonologist on call would be contacted. If there was no pulmonologist on call, or if there was no response to a page, the respiratory therapist would call their Medical Director, Physician F. Physician F is board certified in Pulmonology and in Critical Care. If he was not available, then the "chain of command" was initiated. During a review of ED medical records at IVMC on May 30 and May 31, 2007, the following was noted: a. Patient 105, a 77 year old female, presented to the ED on March 2, 2007, at 12:36 PM, with a chief complaint of "sent by primary doctor for possible stroke." The triage assessment, completed on March 2, 2007, at 1:05 PM, showed that Patient 105 had a headache, depression, was tired and had a droopy left eye. In the ED, a Computerized Tomography (CT) scan of the head revealed a 7 x 12 mm area of bleeding in the intraparenchymal space (inside of the brain). The ED physician's dictated report dated March 2, 2007, showed that the neurosurgeon on staff was paged, and spoken to at home, but "he does not take call within our hospital, he is out of town and is not available." The ED physician made arrangements to transfer Patient 105 to another facility for a "higher level of care." The ED physician then contacted the house supervisor, "and informed her of the transfer situation...and spoke to the hospital administrator and informed her of the situation, that the patient will be	A 186	ALLEGATION OF COMPLIANCE: The Hospital nevertheless respectfully disagrees that the cited examples support the allegation that the Hospital was not enforcing the Bylaws requirement and not attending to the emergency needs of inpatients for the following reasons: Patient #135: The medical record for this patient documents that the patient came through the ED on May 29, 2007, was admitted to an attending internist, was taken to surgery for an emergency tracheostomy, and then was admitted to the ICU at 1510 that same day. --The consulting pulmonologist was present in the operating room and wrote the initial ICU orders. --The record further reflects that the anesthesiologist and pulmonologist remained in the ICU for a period of time after the patient's admission to assist with stabilizing him. --At 2100, the medical record documents that the patient was becoming restless. --At 2130, the nurses paged the attending physician and the pulmonologist because the patient started bucking the ventilator and the nurses needed orders for medication to calm the patient.	

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

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A 186	Continued From page 116 transferred for a higher level of care, as there is no neurosurgical call panel here." Patient 105 was transferred to another facility for neurosurgical services at 11:20 PM, nearly 11 hours after arriving in the ED for treatment. A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two neurosurgeons on active staff. A review of the ED on-call schedule on May 31, 2007, showed that only one neurosurgeon was taking call. b. Patient 118, a 33 year old male, presented to the ED on March 4, 2007, at 2:03 PM, with a chief complaint of an injury to the left leg. An x-ray of the left tibia and fibula showed a "closed comminuted displaced fracture of the left tib-fib" (tibia and fibula). A review of the ED physician's notes showed that "multiple calls were made to the orthopedic physician on call, with no answer." The ED physician transferred Patient 118 to another facility for orthopedic care. c. Patient 119, a 26 year old male, presented to the ED on March 27, 2007, at 10:10 AM, with a chief complaint of multiple seizures after arriving in the recovery room at a local surgery center. Patient 119 continued to have seizures while being transported to the ED by ambulance, and on arrival in the ED. The ED physician diagnosed Patient 119 with Status Epilepticus (uncontrolled seizures). The ED physician's dictated report, dated March 27, 2007, showed that Patient 119 and his family were informed of the treatment plan, "including the potential for transfer to a tertiary care center for neurology, as we have no neurology on-call." The ED physician, "spoke to a	A 186	--At 2205, the nurses spoke with the surgeon on the case and obtained the necessary medication orders. There was no documentation indicating that the nurses paged the attending physician or pulmonologist again (which they obviously did not need to do). At this point, there was no need to document if those physicians responded after the conversation with the surgeon and no need to run the chain of command, which would have triggered the HPRR. --The medical record also does not indicate the patient was having an emergency; vital signs were stable and the patient was described only as "restless" when medicated with Ativan 5 minutes later. Hospital staff confirmed that if the nurses required emergency help, they would have called other members of the healthcare team, run the chain of command, and if necessary, also been able to call one of the ED physicians, who are in house 24/7, 365 days/year, to provide assistance. Patient #201: This patient was thoroughly evaluated by a consulting neurologist on 5/24, and the neurologist followed up concerning the status of the patient on 5/25. The neurologist timely dictated his consultation report and notified the patient's attending physician that he would be out of town starting on 5/25. Although an anecdotal report was given to the surveyor by Physician B suggesting that the patient urgently needed a neurologist who refused to come in, Physician B was not involved in this patient's care, and the 2567 does not	

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A 186	Continued From page 117 staff neurologist, however he was not on call, and agreed with the plan to transfer." The ED physician arranged for Patient 119 to be transferred to another facility, accompanied by a critical care transport team, for neurology care. A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two neurologists on active staff, and two neurologists in provisional status seeking active staff membership. d. Patient 120, a 62 year old male, presented to the ED on April 2, 2007, at 11:58 PM, with a chief complaint of blindness in the right eye. The triage assessment, completed on April 3, 2007, at 12:24 AM, showed that Patient 120 had a sudden onset of loss of vision in his right eye at 10:30 PM, after hitting his head earlier in the day. The ED physician's dictated report, dated April 3, 2007, showed that Patient 120 had signs of a retinal detachment and, "this institution does not have an ophthalmologist on call." Patient 120 was transferred to another facility for a "higher level of ophthalmological care," at 7:43 AM, nearly eight hours after arrival in the ED for treatment. A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two ophthalmologists on active staff, and one ophthalmologist in provisional status seeking active staff membership. e. Patient 121, a 54 year old female, presented to the ED on April 28, 2007, with a chief complaint of vomiting blood. The ED physician's notes showed that the patient was transferred to another facility for a "higher level of care, no GI (Gastroenterology) service on call."	A 186	cite any such problem following chart review. The patient's chart in fact reflects that the consulting neurologist had appropriately notified the admitting physician that he would be out of town and identified other neurologists who would be available to see the patient if necessary. The patient was followed by one of the back-up neurologists on 5/26, although the patient was not having a neurological crisis of any kind. Patient #44: This record indicates that the nurse was calling the consulting pulmonologist to report the results of the patient's morning labwork and the fact that the patient was doing well on the ventilator. The consulting pulmonologist responded to the call timely within 30 minutes and asked the nurse to report the results to another pulmonologist who was covering for him/her that day. The second pulmonologist responded to the page timely within 20 minutes. When the on-call pulmonologist was reached, the physician determined that the patient was stable and gave no new orders. The cited examples do not support a finding of noncompliance with the CoPs, or the conclusion that the Hospital was not attending to the emergency needs of inpatients. For these reasons, the Hospital requests that this citation be removed.	

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A 186	Continued From page 118 A review of the Medical Staff Roster on May 31, 2007, showed that the facility had six gastroenterologists on active staff. f. Patient 122, a 17 year old male, presented to the ED on April 2, 2007, at 1:53 AM, with a chief complaint of an eye injury. The triage assessment, completed on April 2, 2007, at 2:13 AM, showed that Patient 122 was hit in his right eye earlier in the evening, his eye was reddened and teary, he was unable to see out of his right eye when checking his visual acuity, and he had a large right hyphema (bleeding in the anterior chamber of the eye). The ED physician's notes showed that Patient 122 had a large right hyphema, and would be transferred to another facility due to "no ophthalmology on call at Inland Valley." Patient 122 was transferred to another facility at 3:58 AM, for a "higher level of care." A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two ophthalmologists on active staff, and one ophthalmologist in provisional status seeking active staff membership. g. Patient 124, a 17 year old female, presented to the ED on April 13, 2007, at 7:03 PM, with a chief complaint of bloody urine and vomiting. The triage assessment completed on April 13, 2007, at 7:19 PM, showed that Patient 124 had lower abdominal pain, with vomiting every 2 hours for a week. She also complained of weakness and dizziness. The ED physician's notes showed that Patient 124 was in Acute Renal (kidney) Failure, and had Anemia (low blood counts). The ED physician called the pediatrician on call, who was not available to care for Patient 124. Patient 124	A 186		

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A 186	Continued From page 119 was transferred to another facility for care and treatment at 2:11 AM, nearly seven hours after arriving in the ED for treatment. h. Patient 129, a 44 year old male, presented to the ED on April 8, 2007, at 11:50 PM, with a chief complaint of chest pain and shortness of breath. The ED physician's notes showed that the patient had Congestive Heart Failure, Hypertension and Cardiomegaly (enlarged heart). On April 9, 2007, at 4 AM, the physician on call for Internal Medicine was called by the ED physician to admit the patient. At 6 AM, there was no response from the on call physician, and another call was placed. At 7 AM, the on call physician called in to the ED, and agreed to admit the patient. The response time for this on call physician was three hours. The Emergency Medicine (EM) minutes for IVMC were reviewed on May 30, 2007, at 10:45 AM, and again on May 31, 2007, at 12:55 PM. There was no evidence of a discussion regarding the lack of availability of specialists on-call on weekends and evenings. In September 2006, Page two, section D of the minutes was titled, "Call panel Validation." The minutes stated, "For physicians not on suspension, the ED has calling been to confirm assigned call. The CEO indicated she is working on a plan/process for everyone, and will give information to the ED Medical Director. The CEO indicated the verification of daily assigned call will not be done through the Medical Staff Office." During an interview with the Director of the ED on May 31, 2007, at 11:35 AM, she stated that she was aware that the ED on call schedule did not include all specialties that were offered by the	A 186		

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A 186	Continued From page 120 facility. The ED Director stated that she was aware that patients were transferred out of the ED as a result of not having specialty call coverage, and stated that it occurred approximately twice a month to her knowledge, but she only heard about the "particularly messy patients". She stated that the ED physicians complained regularly about the lack of specialty on call coverage, and that they were supposed to be informing the administrator on call every time a patient was transferred to another facility due to no specialist available to care for the patient, then do an HPRR. The ED Director stated that this issue had been reported to administration, and administration answered, "we're discussing it". She stated that this was a "closed administration at the senior level", and that they did not share information with the management team. During an interview with the Director of Performance Improvement (PI) on May 31, 2007, at 12:10 PM, she stated that the issue of not having specialists on call for the ED was discussed "regularly" in the ED committee meetings, and PI was not involved because "we already knew we had a problem". The Medical Director of the ED (also a member of the Board of Directors) was interviewed on May 31, 2007, at 1:20 PM. He stated that the voluntary call system was "inconvenient" and that often patients were transferred for the lack of an available specialist. He stated that "It's a problem" and that he had empathy for the patients. He stated the primary issue was customer satisfaction. He stated that although many specialties did not have a physician on-call, Urology was the most common specialty to have nobody who would come in to see a patient. He	A 186		

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A 186	Continued From page 121 stated the problem with ventilated patients had improved since Physician D joined the pulmonary/intensive care team. However, Physician D was only on-call one week every four weeks. He stated that the ED physicians were "working with what we have to work with." He further stated that no Quality Assurance/Performance Improvement (QAPI) activities were being done to determine the effect the voluntary call system had on patient care, transfers or time spent trying to find a consultant. The Medical Director stated that he spoke at one of the Medical Executive Committee (MEC) meetings, and he told the committee about the difficulty dealing with the voluntary call system; "but until you are in my shoes, looking into the patient's eyes, you cannot know how we (the ED physicians) feel." Findings at RSMC: During a review of ICU medical records on June 1, 2007, the following was noted: Patient 44, a 91 year old male, was admitted to the ICU on May 31, 2007, on a ventilator (breathing machine). On June 1, 2007, at 6 AM, the ICU nurse paged Pulmonologist #1, who had done the initial pulmonary consult for ventilator management, to report blood gas results (to show how well the ventilator is assisting the lungs). There was no response, so the ICU nurse repaged Pulmonologist #1 at 6:20 AM. At 6:30 AM, Pulmonologist #1 called back and said he was not on call, but Pulmonologist #2 was. At 6:35 AM, the ICU nurse paged Pulmonologist #2. At 6:45 AM, there was no response from Pulmonologist #2, so the nurse paged again. At 6:45 AM, there was still no response from	A 186		

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A 186	Continued From page 122 Pulmonologist #2, so the ICU nurse paged the house supervisor for assistance. At 6:50 AM, Pulmonologist #2 returned his page to the ICU nurse. During an interview with ICU RN 4 on June 1, 2007, at 11:50 AM, the nurse stated that the pulmonology service had been a problem when they were trying to get somebody to manage the patient on a ventilator, but their biggest problem was with neurology. She stated that the neurologists did not have to be on call, and MD 3 told them that he did not have to take call, so if he did not want to come in, he did not have to. ICU RN 4 stated that the ICU nurses made multiple phone calls, and spent hours of their days on the telephone trying to get in touch with doctors. Physician B, a neurologist who provided services at both hospitals, was interviewed on June 1, 2007 at 1:55 PM, by telephone. He stated that there were four neurologists on staff, and that they went to a voluntary call schedule because the call was causing "burn out" among the physicians. Physician B stated the ED physicians were "pathological dumpers" who didn't want to work-up the patients in the ED. He emphasized that the hospital was not supporting them. He also stated that the administration had arranged call coverage with a new contracted neurologist, but that she was unavailable to come to the facility when she was supposed to be on call, stating that she was not on call, or in Los Angeles. Physician B recommended the survey team review the chart of Patient 201. Reportedly, Patient 201 was an inpatient in the ICU at IVMC. The neurologist involved in the case told the admitting physician that he would be out of town. When a neurologist was urgently needed, the	A 186		

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A 186	Continued From page 123 contracted physician was contacted, but was unable or unwilling to come to the facility to provide consultative services for Patient 201. During an interview with ICU RN 5 on June 1, 2007, at 2:43 PM, she stated that she wrote a verbal order for a neurology consult that morning for MD 4 to do. She stated she called MD 4, and was told that MD 5 was on call for neurology, so to call that physician instead. ICU RN 5 called MD 5, and was told that MD 3 was on call for neurology, so call that physician instead. ICU RN 5 stated that if she needed to know who was on call for a specialty, she called the offices and asks if they knew. When she was asked who was on call for neurology that day (June 1, 2007), she answered, "I guess it's MD 3". ICU RN 5 stated that she did not have a call list, but she could call the ED to see who was on call. When she was asked if she was aware that there was nobody on call for neurology for the ED, she stated, "no". In the ICU on June 1, 2007, at 2:52 PM, in the presence of four ICU nurses and three ICU managers, a general question was asked of them, how much time do you spend making calls to try to find physicians? They all answered, "a lot". Physician G, an Internal Medicine doctor serving both hospitals, was interviewed on June 1, 2007 at 3:25 PM at RSMC. He stated that there had been a "couple of instances" when he had a patient who needed a Neurology consult and was unable to obtain one. He also said that he generally called Physician F when he needed a pulmonology/critical care consult, bypassing the on-call schedule, because he got a better	A 186		

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A 186	Continued From page 124 response. He added that "In general, it is not easy to get consultations at this hospital." He also stated that there was poor communication between doctors and administration. During a review of ED medical records on June 1, 2007, the following was noted: a. Patient 31, an 84 year old male, presented to the ED on April 20, 2007, at 5:57 PM, with a chief complaint of a syncopal (dizzy) episode and a fall. The triage assessment, completed on April 20, 2007, at 6:06 PM, showed that Patient 31 had a hematoma (blood pocket under the skin) above the left eye and on the left forehead, and had a headache. The nurse's notes showed that the patients headache continued throughout the ED stay, and he was medicated on five different occasions for the pain. The ED physician dictated report showed that Patient 31 had a Computerized Tomography (CT) scan of his head, that showed a subdural hematoma (bleeding in the brain) on the right side. The ED physician noted that the facility neurosurgeon was not on call that day, and "he (Patient 31) will be transferred for a higher level of care, we do not have a neurosurgeon on call at this time". Patient 31 was transferred to another facility at 9 PM, with a blood pressure of 195/66, accompanied by a critical care transport team, for a "higher level of care". A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two neurosurgeons on active staff, and only one neurosurgeon was serving on the ED backup call schedule. A review of the April 2007 Emergency	A 186		

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A 186	Continued From page 125 Department On-Call Schedule on May 31, 2007, showed that there was a neurosurgeon scheduled to be on call on April 20, 2007. b. Patient 36, a 60 year old male, presented to the ED on April 4, 2007, at 3:47 AM, with a chief complaint of abdominal pain. The ED physician dictated report showed that the patient had a kidney stone on the right side, and needed to be seen by a urologist. The ED physician contacted a urologist on staff at the facility, who did not come in to see Patient 36. Patient 36 was transferred to another facility at 8:50 AM, for urology care. A review of the Medical Staff Roster on May 31, 2007, showed that the facility had six urologists on active staff. A review of the ED on-call schedule on June 1, 2007, showed the urology service ED call listed as "voluntary". c. Patient 40, a 43 year old male, presented to the ED on April 23, 2007, at 10:28 AM, with a chief complaint of sore throat. The ED physician dictated report showed that Patient 40 had a peritonsillar abscess (an abscess around the tonsils), and was having difficulty swallowing. The ED physician noted that he, "discussed transferring the patient for ENT (Ear, Nose and Throat) services, as we have no ear/nose/throat specialist on call today". Patient 40 was transferred to another facility at 12 PM for a "higher level of care for ENT services". A review of the Medical Staff Roster on May 31, 2007, showed that the facility had three ENT physicians on active staff.	A 186		

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A 186	Continued From page 126 A review of the ED on-call schedule on June 1, 2007, showed the ENT service was not listed on the call schedule, either as voluntary or mandatory. d. Patient 203, an elderly female, presented to the ED on May 21, 2007, by ambulance, with a complaint of abdominal pain. The patient had a Computerized Tomography (CT) scan of the abdomen, which was normal. A repeat CT with contrast (used to enhance the image) showed gastritis (inflammation of the stomach). The final diagnoses were Elevated Digoxin Level (a medication used to stimulate a failing heart) and Acute Gastritis. The patient was transferred to another facility for treatment. No documentation was present regarding the reason for transfer. Both of the transfer diagnoses were common medical conditions, usually treated by a cardiologist and a gastroenterologist. Both services were offered at this hospital, however the Gastroenterologists were on a voluntary call schedule for ED back up. e. Patient 204, an elderly female, presented to the ED on May 21, 2007. The physician's notes indicated that she was to be admitted to the telemetry unit with a diagnosis of Cerebral Vascular Accident (CVA, stroke). The nurses notes also stated "Admit to telemetry". Patient 204 was instead transferred to another facility. No documentation was present regarding why the admission was changed to a transfer. A CVA was a common neurological condition, usually treated by a neurologist. The hospital provided neurology services, but the neurology service had a voluntary call schedule for ED back up.	A 186		

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A 186	Continued From page 127 f. Patient 205, a young man, presented to the ED on May 5, 2007, with a chief complaint of an eye injury. The ED physician noted that there was a laceration to the upper eyelid that would require the services of a plastic surgeon, a specialty service that is offered at this hospital. However, plastic surgery physicians are on a voluntary call schedule. The patient was transferred to another facility for care. g. Patient 206, a female patient, presented to the ED on May 29, 2007, via paramedics, with a chief complaint of inability to speak and right sided weakness. The ED physician's notes indicated the patient had a probable CVA. This was a common neurological condition usually handled by a neurologist, a service offered at this hospital. Patient 206 was transferred to another facility. The ED physician's notes stated, "We do not have neurology on call." Physician E was the prior ED director, and sat on both the Medical Executive Committee (MEC) and the hospital board. He was interviewed on May 31, 2007, at 2:30 PM. Physician E stated that he was taking the Chief of Staffs (COS) place in the interview, since she was not available. He stated he had "no perception" of any Quality Assurance/Performance Improvement (QAPI) activities relating to the effects of the institution of voluntary call for specialties on patient care either in the ED or ICU. He stated that the MEC in general seemed to be a "mixed bag" when it comes to the voluntary call. The committee had to balance pro patient care sentiment with pro voluntary call sentiment. He mentioned that there are three staff physicians on the board. He described how the MEC informed the COS that there would be no patient safety issues with	A 186		

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A 186	Continued From page 128 voluntary call. The COS, in her reports to the Board, tried to use this information to convince the Board to approve the change in bylaws to allow for voluntary call panels. The COS was not available for comment. Dr. E further stated that at the Board retreat in November, 2006, further discussion about voluntary call occurred, at which time the COS continued to push for the change. During an interview with the ED Unit Secretary (US) on June 1, 2007, at 10:40 AM, the US stated that when she needed to call a specialty physician, she asked the ED physician or the patient's primary care physician (PCP) which specialist they wanted her to call. She then called that specialist and asked them if they would "consider" taking care of the patient. If the specialist declined, she asked the ED physician or the PCP who to call next, and she continued until she found a specialist that was "willing" to take care of the patient. The US stated that she was "usually" able to find somebody to come in. She stated that if they were unable to find a specialist, then the patient got transferred to another facility, but "that doesn't happen very often". During an interview with ED Physician 2 on June 1, 2007, at 11:13 AM, he stated that the voluntary call system "made the job more difficult". ED Physician 2 stated that he had been using the Internal Medicine (IM) or Family Practice (FP) physician for advice on what specialist to call. He stated that it took longer to get a specialist now that it was voluntary, and he had to make multiple calls, but he could usually get somebody to come in.	A 186		
A 452	482.55 EMERGENCY SERVICES	A 452		

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A 452	Continued From page 129 The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to ensure that Emergency Services were provided in a manner that met the needs of the patients in accordance with acceptable standards of practice for the provision of on-call physician coverage to the Emergency Department (ED) for services that the facility offered to the public. The facility failed to ensure that: 1. The Medical Staff provided ongoing and continuing assessment of the medical care provided in the ED, to establish and/or revise policies and procedures governing the ED medical care, based on Quality Assurance and Performance Improvement. (A0456). 2. There was adequate on-call physician coverage for patients in need of specialized treatment when the facility had the capacity to treat the individual (A0459). The cumulative effect of this systemic problem resulted in the failure of Emergency Services to ensure that patients received quality medical care in a safe patient environment.	A 452	The Governing Body reviewed what the Medicare rules and conditions of participation concerning what is required to "meet the emergency needs of patients in accordance with acceptable standards of practice." The Governing Body met to review the citations and the options for addressing the identified deficiencies. The Governing Body also considered the factors that CMS has set forth in the State Operations Manual concerning emergency services and on-call requirements. The Governing Body noted specifically the CMS Interpretive Guidelines that explain what is meant by meeting patients' emergency needs in accordance with acceptable standards of practice. The Governing Body noted that the Emergency Medical Treatment and Labor Act (EMTALA) addresses specific on-call requirements for hospitals furnishing emergency services, and that the 2567 does not cite any other acceptable standards of practice. Please see specific actions taken and allegations of compliance under Tags A186, A 456, and A 459.	06/18/07 06/18/07 06/18/07 06/18/07
A 456	482.55(a)(3) POLICIES The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff. This STANDARD is not met as evidenced by: Based on interview and record review, the facility	A 456	In addiition to the other actions under A186 and A 459, the Governing Body reviewed the CMS Interpretive Guidelines and survey procedures regarding the requirements for ongoing QAPI activities and the responsibility of the Medical Staff with	06/18/07

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A 456	Continued From page 130 failed to ensure that the medical staff provided ongoing and continuing assessment of the medical care provided in the Emergency Department (ED), and established and/or revised the policies and procedures regarding practices in the ED based on Quality Assurance and Performance Improvement (QAPI) activities. Findings: On May 30, 2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated the practice for the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the Governing Body initially approved the voluntary call system on a trial basis for 90 days, and subsequently extended the trial time on two separate occasions. The current on-call physician coverage for the facility was voluntary. On May 30, 2007, the Medical Staff Bylaws that were revised on February 26, 2007, were reviewed. The Bylaws specified, "Each active medical staff member shall actively participate on, and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including but not limited to emergency services and back-up functions....Provisional staff members seeking Active staff membership shall participate in emergency services and back-up functions." The facility Performance Improvement Plan was reviewed on May 30, 2007. The plan included the following:	A 456	respect to ongoing and continuing assessment of medical care provided in the ED. The Hospital's Governing Body and Medical Executive Committee (MEC) reviewed and confirmed that Medical Staff departments, including the ED Department, regularly review medical care furnished to ED patients. --ED PI activity is completed regularly on specific cases. --Data is trended and monitored regarding the number of ED patients seen and the number of transfers occurring, among other things. --Data is tracked at the ED level, and information is reported up through the ED Department to the MEC, and then to the Governing Body as indicated. --Cases of concern may also be referred to the PI/RM Committee for peer review of unresolved issues/concerns after review by the physician's peers/ department. The Hospital's Governing Body and MEC reviewed and confirmed that the QAPI system was monitoring the completeness of transfer documentation, as noted in the citation. The Hospital Governing Body and MEC leadership reviewed and confirmed that participation on the call panel for the ED is not mandatory at this time, but that when a physician agrees to participate on the call panel and is on call for the ED, the	06/26/07 06/26/07 06/18/07

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A 456	Continued From page 131 1. Objectives for provision of care which included: a. A mechanism to assure that all patients received the same level of care; and b. A culture where care was delivered in a safe environment, and quality care was measured, monitored and continuously improved. 2. The responsibilities of the Governing Board included a duty to assure patient care was safely delivered within the guidelines established by the Medical Staff. 3. The Medical Executive Committee of the Medical Staff was accountable to the Governing Board to ensure care was delivered in accordance with the Medical Staff Bylaws, Rules and Regulations. 4. Measuring and monitoring performance included ensuring that processes, functions or services were designed/redesigned well, and met the needs of the individuals served. The ED Quality Assurance/Performance Improvement (QAPI) was reviewed on May 30, 2007. The ED was monitoring compliance with EMTALA transfer regulations, on a quarterly basis, in the following areas: a. The patient's condition was documented; b. The accepting facility was documented; c. The accepting physician was documented; d. Appropriate paperwork was sent with the patient; e. The method of transportation was documented; f. Vital signs were done within 15 minutes of transfer; g. The physician defined the reason for transfer;	A 456	physician MUST respond to the Hospital timely when called, MUST come to the Hospital timely to render care when requested, and MUST see all unassigned patients as requested. Administration analyzed transfers for the previous 3 months with a focus on several subspecialties that have little to no coverage, and determined that the majority of transfers were for services the Hospital does not offer (e.g., interventional cardiology, psychiatry, neonatal intensive care (NICU) services), and confirmed that only a very small percentage of transfers occurred because the ED lacked specialist coverage at the time. The Hospital's Governing Body reviewed and confirmed that: --The ED sees approximately 5,000 patients a month; --The ED transfers a very small percentage of those patients because the Hospital maintains 24/7, 365 days/year coverage for multiple specialist categories that address most emergent needs (e.g., Internal Medicine/Family Practice, Pediatrics, OB/Gyn, General Surgery, Trauma Surgery, Orthopedic Surgery, and Anesthesiology), and nearly 24/7, 365 days/year coverage for Cardiology and Neurosurgery (except 2-4 days/month); --The majority of transfers from the ED are because the patient needs a service the Hospital does not offer, such as interventional cardiology, psychiatry, or neonatal intensive care (NICU) services.	06/01/07 06/18/07

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A 456	Continued From page 132 and h. The consent was signed and witnessed. There was no monitoring regarding the reason for transfer, availability of on-call physician services, appropriateness of transfers or outcomes related to transfers. The Medical Staff and Governing Board had no QAPI data to assess the quality of care provided by the on-call physician services in the ED, or to determine if changes in policies were appropriate, necessary and would meet the needs of the individuals served. The facility transfer policy was reviewed on May 30, 2007. The policy stated that, "The policy and philosophy of Southwest Healthcare System (SWHCS), emergency services and care will be provided to any individual who requests services...." The policy also stated that, "Unless extenuating circumstances are present, no patient will be transferred to another facility if SWHCS has the means to provide the care." Some conditions that required transfer to another facility included, "If physician specialty is unavailable due to gaps in the on-call physician schedule..." The Emergency Medicine (EM) minutes were reviewed on May 30, 2007, at 10:45 AM, and again on May 31, 2007 at 12:55 PM. There was no evidence of a discussion regarding the lack of availability of specialists on-call on weekends and evenings. The Medical Director of the ED (also a member of the Board of Directors) was interviewed on May 31, 2007, at 1:20 PM. He stated that the voluntary call system was "inconvenient" and that often patients were transferred for the lack of an	A 456	--The rate of transfers when physician participation in ED call coverage was mandatory was essentially the same as the rate of transfers under the current system where physicians may elect not to participate on the ED call panel (although as noted above, when a physician elects to take call for the ED, he/she MUST respond to the ED and care for unassigned patients as requested); --The specialties for which there is call coverage have not decreased in the last year, but in fact have increased with the addition of neurosurgery coverage. The "voluntary call" system has been workable because the medical staff has been able to provide 24/7 coverage for almost 365 days/year in the major areas identified above and in A 459; --Administration and Medical Staff leadership are in the process of negotiating further improvements to the call panel to include teleneurology coverage for the ED; a NICU is currently under construction, and interventional cardiology is scheduled to begin construction in 2008. Hospital Administration enhanced the ongoing monitoring of a random sample of transfers to evaluate: --The appropriateness of and reasons for transfers, with attention to transfers because the Hospital does not offer a particular service and because the ED lacks specialist coverage, and --Overall transfer rates.	06/29/07

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A 456	Continued From page 133 available specialist. He stated that "It's a problem" and that he had empathy for the patients. He stated the primary issue was customer satisfaction. He stated that although many specialties did not have a physician on-call, Urology was the most common specialty to have nobody who would come in to see a patient. He stated the problem with ventilated patients had improved since Physician D joined the pulmonary/intensive care team. However, Physician D was only on-call one week every four weeks. He stated that the ED physicians were "working with what we have to work with." He further stated that no Quality Assurance/Performance Improvement (QAPI) activities were being done to determine the effect the voluntary call system had on patient care, transfers or time spent trying to find a consultant. The Medical Director stated that he spoke at one of the Medical Executive Committee (MEC) meetings, and he told the committee about the difficulty dealing with the voluntary call system; "but until you are in my shoes, looking into the patient's eyes, you cannot know how we (the ED physicians) feel." During an interview with the Director of Performance Improvement (PI) on May 31, 2007, at 12:10 PM, she stated that the issue of not having specialists on call for the ED is discussed "regularly" in the ED committee meetings, and PI is not involved because "we already knew we had a problem".	A 456	The PI/RM Committee is responsible for analyzing the monitoring results, for taking actions as appropriate, and for reporting information as indicated monthly to the MEC and, as appropriate, to the Governing Body, which meets 10 times during the year. The PI/RM Committee reviewed data on transfers and the reasons for transfer and drew the same conclusions noted above by Administration and the Governing Body. ALLEGATION OF COMPLIANCE WITH A 456: The Hospital nevertheless respectfully disagrees that the citation supports a violation of this rule. Medical and administrative leadership regularly evaluate emergency coverage and anticipated emergency needs on an ongoing basis—as the surveyors saw, this ongoing evaluation is a regular topic of discussion at leadership meetings. The 2567 itself details one of the QAPI monitors used by the Hospital to evaluate transfers. Other monitoring also tracks the number of transfers. The Hospital has determined that it continues to see approximately 5,000 patients a month in the ED; that it transferred a small percentage of its ED patients when there was mandatory call; that it continues to transfer essentially the same small percentage of patients under the current system where physicians elect whether to participate on the call panel for the ED; and that the vast number of these transfers are for services the Hospital does not	06/29/07 & ongoing 07/09/07
A 459	482.55(b)(2) QUALIFIED PERSONNEL There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility.			

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A 456		A 456	currently offer, such as psychiatry, interventional cardiology, and NICU services. This consistency in the data indicates that the shift to a system where physicians elect whether to be on the ED call roster has not changed the Hospital's call capability or increased the need to transfer patients. A majority of those transfers are necessary not because the Hospital does not have emergency coverage for a given specialty, but because the Hospital does not offer the service or procedure the patient needs. As a result of this analysis, the Hospital is taking steps to add identified specialties such as interventional cardiology and a NICU. For these reasons, the Hospital submits that the Hospital was and is in compliance with the rules; and that this citation should be removed.	

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A 459	Continued From page 134 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate on-call physician coverage to meet the needs of nine of 56 patients needing emergency services at IVMC (Patients 105, 118, 119, 120, 121, 122, 124, 129 and 202), and seven of 68 patients (Patients 31, 36, 40, 203, 204, 205 and 206) needing emergency services at RSMC. Findings: On May 30, 2007, at 8:45 AM, an entrance conference was held with the Chief Executive Officer (CEO) and the Chief Nurse Executive (CNE). The CEO and the CNE stated the practice of the Emergency on-call physician coverage was changed from mandatory to voluntary in August, 2006. They stated the Governing Body initially approved the voluntary call system on a trial basis for 90 days, and subsequently extended the trial time on two separate occasions. At this time, the on-call physician coverage remained voluntary. The meeting minutes for the Emergency Medicine Department were reviewed on May 30, 2007, at 10:50 AM. The minutes, dated September 2006, included a section titled, "Call Panel Validation", which specified, "For physicians not on suspension, the ED had been calling to confirm assigned call. The CEO indicated she is working on a plan process for everyone and will give information to ED Medical Directors. The CEO indicated the verification of daily assigned call will not be through the Medical Staff Office." The meeting minutes for the Family Practice	A 459	In addition to actions detailed under A 186 with respect to inpatients, the Hospital has taken the following actions with respect to emergency services furnished in the ED: Regarding current call coverage for the Hospital ED, the Governing Body considered the Medicare Interpretive Guidelines and Survey procedures concerning the Emergency Services Condition of Participation and of the more specific EMTALA rules, and reviewed the anticipated emergency needs of the Hospital's patients. The Governing Body reviewed and confirmed the staffing of the ED with appropriate personnel and with ED physicians qualified to handle most emergencies. The Governing Body revisited the following key factors with respect to the Hospital's staffing of the on-call roster for the ED: --What specialties met the most frequent needs for emergency services and the fact that these specialties should be scheduled to be on call for the ED as close to 24/7, 365 days/year as possible. These specialties are: medicine/family practice, general surgery, orthopedics, obstetrics/gynecology, cardiology, trauma surgery, neurosurgery, pediatrics, and anesthesiology; --What services and facilities the Hospital offered, including the services and facilities the Hospital did not offer	06/18/07 06/18/07 06/18/07 & 07/03/07

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A 459	Continued From page 135 Department were reviewed on May 30, 2007. In the minutes dated November 29, 2006, there was a report by ED Physician B for ED Physician C, that advised, "Since call is currently voluntary, written agreements are currently in progress by administration for specialists. We currently do not have a formal call panel for Neurology, ENT, Pulmonology, and Ophthalmology, causing patients to be transferred." The minutes for March 2007, were also reviewed. In the first paragraph of the executive session was the statement, "The department noted that neurosurgeons have the choice to respond or not to a consult request." On May 30, 2007, the current Medical Staff Bylaws that were revised on February 26, 2007, were reviewed. The Bylaws specified that, "Each active medical staff member shall actively participate on, and cooperate with the Medical Staff to assist the hospital in fulfilling its obligations related to patient care, including but not limited to emergency services and back-up functions....Provisional staff members seeking Active staff membership shall participate in emergency services and back-up functions." On May 30, 2007, the Emergency Department back-up specialty call schedules for April, May and June, 2007, were reviewed . The following specialties had no formal call panel: a. Allergy (one physician on staff); b. Dentistry (one physician on staff); c. Dermatology (one physician on staff); d. Endocrinology (three physicians on staff); e. Gastroenterology (eleven physicians on staff); f. Hematology/Oncology (seven physicians on staff); g. Infectious Diseases (two physicians on staff);	A 459	(e.g., the fact that the Hospital does not have a psychiatric unit, a NICU, interventional cardiology, or the specialized equipment to perform complex opthalmology procedures such as the surgery to repair retinal detachment); --The types of emergency services that the emergency physicians can provide without the need for a specialty consult or specialty evaluation in the ED because they have the training and experience to provide them, with the assistance of internists/family practitioners, orthopedists, and surgeons who are on call for the ED 24/7, 365 days/year. Such services include, e.g., allergy, dermatology, podiatry, radiation/oncology, hematology/oncology, etc.; -- The number of physicians on staff, including the number on active staff in each specialty who have committed to provide on-call coverage for the ED; --Other demands on these physicians (practice and surgery schedules, participation in medical staff leadership activities, peer review activities, utilization review, vacations, requirements to obtain continuing medical education, etc.); --The frequency with which the Hospital's patients typically require services of certain specialists in the ED; --The provisions the Hospital has made for situations in which a physician in a particular specialty is not on call or the on-call physician is unable to respond.	

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A 459	Continued From page 136 h. Nephrology (three physicians on staff); i. Neurology (three physicians on staff); j. Ophthalmology (three physicians on staff); k. Oral Surgery (three physicians on staff); l. Pain Management (four physicians on staff); m. Plastic Surgery (six physicians on staff); n. Podiatry (nine physicians on staff); o. Psychiatry (one physician on staff); p. Pulmonology (four physicians on staff); q. Radiation Oncology (three physicians on staff); r. Rheumatology (one physician on staff); s. Urology (five physicians on staff); and, t. Vascular Surgery (two physicians on staff). During a review of medical records on May 30, 2007, the following was noted: a. Patient 119, a 26 year old male, presented to the ED on March 27, 2007, at 10:10 AM, with a chief complaint of multiple seizures after arriving in the recovery room at a local surgery center. Patient 119 continued to have seizures while being transported to the ED by ambulance, and on arrival in the ED. The ED physician diagnosed Patient 119 with Status Epilepticus (uncontrolled seizures). The ED physician's dictated report, dated March 27, 2007, showed that Patient 119 and his family were informed of the treatment plan, "including the potential for transfer to a tertiary care center for neurology, as we have no neurology on-call." The ED physician, "spoke to a staff neurologist, however he was not on call, and agreed with the plan to transfer." The ED physician arranged for Patient 119 to be transferred to another facility, accompanied by a critical care transport team, for neurology care. A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two	A 459	Such provisions include: * The ability to have a general surgeon, trauma surgeon, orthopedic surgeon, obstetrician, pediatrician, neurosurgeon, family practitioner, internist, or hospitalist admit the patient to render appropriate care, * If a transfer is necessary, having readily available to ED staff a prioritized list of other facilities that are capable of handling various conditions so the ED immediately calls appropriate facilities to seek a transfer, and * Having transfer agreements in place with a number of other facilities to streamline transfer arrangements if those facilities are the appropriate places to send the patient. Hospital Administration and Governing Body members noted that: --CMS recognizes that the Hospital "has the discretion to maintain the on-call list in a manner that best meets the needs of the hospital's patients who are receiving services required under EMTALA" in accordance with the resources available to the hospital, including the availability of on-call physicians. --While CMS recognizes that it is a best practice that the particular services a hospital offers to the public should be	06/18/07

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A 459	Continued From page 137 neurologists on active staff, and two neurologists in provisional status seeking active staff membership. b. Patient 120, a 62 year old male, presented to the ED on April 2, 2007, at 11:58 PM, with a chief complaint of blindness in the right eye. The triage assessment, completed on April 3, 2007, at 12:24 AM, showed that Patient 120 had a sudden onset of loss of vision in his right eye at 10:30 PM, after hitting his head earlier in the day. The ED physician's dictated report, dated April 3, 2007, showed that Patient 120 had signs of a retinal detachment and, "this institution does not have an ophthalmologist on call." Patient 120 was transferred to another facility for a "higher level of ophthalmological care," at 7:43 AM, nearly eight hours after arrival in the ED for treatment. A review of the Medical Staff Roster on May 30, 2007, showed that the facility had two ophthalmologists on active staff, and one ophthalmologist in provisional status seeking active staff membership. Further review of IVMC medical records on May 30, May 31and June 1, 2007 showed: a. Patient 105, a 77 year old female, presented to the ED on March 2, 2007, at 12:36 PM, with a chief complaint of "sent by primary doctor for possible stroke." The triage assessment, completed on March 2, 2007, at 1:05 PM, showed that Patient 105 had a headache, depression, was tired and had a droopy left eye. In the ED, a Computerized Tomography (CT) scan of the head revealed a 7 x 12 mm area of bleeding in the intraparenchymal space (inside of the brain). The ED physician's dictated report dated March 2,	A 459	available through on-call coverage of the ED, CMS also recognizes that a hospital is not required to have 24/7 coverage in all specialties, and that implementing such coverage in some specialties (e.g., allergy or certain subspecialties with very few physicians) would detract from the availability of the most needed specialists, such as internists/family practitioners, general surgeons, orthopedists, trauma surgeons, neurosurgeons, pediatricians, OB/GYN specialists, and cardiologists. Administration and ED Physician Leadership reviewed and confirmed there was call coverage for the following specialties, and noted that the citation is mistaken when it says that the Hospital does not have call coverage for neurology and pulmonology, which are provided as follows: --Anesthesiology (on call 24/7, 365 days/year) --Internal Medicine/Family Practice (on call 24/7, 365 days/year) --Pediatrics (on call 24/7, 365 days/year) --OB/Gyn (on call 24/7, 365 days/year) --General Surgery (on call 24/7, 365 days/year) --Orthopedic Surgery (on call 24/7, 365 days/year) --Trauma Surgery (on call 24/7, 365 days/year) --Neurosurgery (on call 24/7 for all but 2-4 days each month) --Cardiology (on call 24/7, nearly 365 days/year)	07/02/07

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A 459	Continued From page 138 2007, showed that the neurosurgeon on staff was paged, and spoken to at home, but "he does not take call within our hospital, he is out of town and is not available." The ED physician made arrangements to transfer Patient 105 to another facility for a "higher level of care." The ED physician then contacted the house supervisor, "and informed her of the transfer situation...and spoke to the hospital administrator and informed her of the situation, that the patient will be transferred for a higher level of care, as there is no neurosurgical call panel here." Patient 105 was transferred to another facility for neurosurgical services at 11:20 PM, nearly 11 hours after arriving in the ED for treatment. A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two neurosurgeons on active staff. A review of the ED on-call schedule on May 31, 2007, showed that only one neurosurgeon was taking call. b. Patient 118, a 33 year old male, presented to the ED on March 4, 2007, at 2:03 PM, with a chief complaint of an injury to the left leg. An x-ray of the left tibia and fibula showed a "closed comminuted displaced fracture of the left tib-fib" (tibia and fibula). A review of the ED physician's notes showed that "multiple calls were made to the orthopedic physician on call, with no answer." The ED physician transferred Patient 118 to another facility for orthopedic care. c. Patient 121, a 54 year old female, presented to the ED on April 28, 2007, with a chief complaint of vomiting blood. The ED physician's notes showed that the patient was transferred to	A 459	--Neurology (currently on call 24/7 for 7 days a month, with efforts underway to add teleneurology on an expedited basis to provide 24/7 coverage for the rest of each month) --Pulmonology (24/7 for 7 days a month, and because most pulmonary emergencies involve managing patients on a ventilator, a combination of pulmonologists and internists newly credentialed to managed ventilator patients enables additional on call coverage for ventilator patients 24/7 for 20+ days per month, with a goal of coverage nearly every day) --Vascular Surgery (covered by a specific vascular surgeon when scheduled on Trauma Surgery call panel) Administration and ED Physician Leadership reviewed the specialties not covered by the ED call panel or where there are gaps in coverage, confirmed that it would not be appropriate for some specialties to take call because they do not typically treat emergencies, and therefore identified the appropriate practitioners who provide coverage and who are qualified to assess and provide stabilizing treatment for ED patients with emergencies: --Allergy: ED physicians on site 24/7 for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365 days/year; allergists do not usually handle emergencies --Dentistry: See Oral Surgery; the only dentist on staff practices general dentistry, and any dental emergencies are actually oral surgery issues	07/02/07

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A 459	Continued From page 139 another facility for a "higher level of care, no GI (Gastroenterology) service on call." A review of the Medical Staff Roster on May 31, 2007, showed that the facility had six gastroenterologists on active staff. d. Patient 122, a 17 year old male, presented to the ED on April 2, 2007, at 1:53 AM, with a chief complaint of an eye injury. The triage assessment, completed on April 2, 2007, at 2:13 AM, showed that Patient 122 was hit in his right eye earlier in the evening, his eye was reddened and teary, he was unable to see out of his right eye when checking his visual acuity, and he had a large right hyphema (bleeding in the anterior chamber of the eye). The ED physician's notes showed that Patient 122 had a large right hyphema, and would be transferred to another facility due to "no ophthalmology on call at Inland Valley." Patient 122 was transferred to another facility at 3:58 AM, for a "higher level of care." A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two ophthalmologists on active staff, and one ophthalmologist in provisional status seeking active staff membership. e. Patient 124, a 17 year old female, presented to the ED on April 13, 2007, at 7:03 PM, with a chief complaint of bloody urine and vomiting. The triage assessment completed on April 13, 2007, at 7:19 PM, showed that Patient 124 had lower abdominal pain, with vomiting every 2 hours for a week. She also complained of weakness and dizziness. The ED physician's notes showed that Patient 124 was in Acute Renal (kidney) Failure, and had Anemia (low blood counts). The ED	A 459	--Dermatology: ED physicians on site 24/7 for 365 days/year, and Internists/Family Practitioners on call 24/7 for 365 days/year (to the extent a patient may have a dermatological emergency) --Endocrinology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Gastroenterology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Hematology/Oncology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Infectious Diseases: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Nephrology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Neurology (when there is a gap in coverage): ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year, and Neurosurgeons on call 24/7 for all but 2-4 days/month --Ophthalmology: ED physicians on site	

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A 459	Continued From page 140 physician called the pediatrician on call, who was not available to care for Patient 124. Patient 124 was transferred to another facility for care and treatment at 2:11 AM, nearly seven hours after arriving in the ED for treatment. f. Patient 202, an elderly gentleman with left-sided weakness and pneumonia was hospitalized in ICU at IVMC during the time of survey. On May 31, 2007, at 8:15 AM, Patient 202 suffered a deterioration of his respiratory status. The nurses notes contained the timeline of events. Physician H, a neurologist, was at the bedside of Patient 202 when the nurses called Physician F, a Pulmonologist/Intensivist, also Medical Director for Respiratory Services, for assistance with an emergency intubation (placement of a breathing tube into the lungs). According to the nurses notes, Physician F was unavailable to come to the hospital. The nurses then paged Physician I to assist with an emergency intubation. Physician I is also a Pulmonary/Critical Care specialist, although he was not listed on the on-call schedule. The nurses informed Physician I that the patient required emergency intubation, but he was unavailable to come to the hospital at that time. A code blue (patient needing resuscitation team) was called and physician J, an ED physician, responded and intubated the patient at approximately 9:05 AM, 50 minutes after the patient was identified to be in severe respiratory distress requiring mechanical ventilation (breathing machine). During an interview with the Director of the ED on May 31, 2007, at 11:35 AM, she stated that she was aware that the ED on call schedule did not include all specialties that were offered by the	A 459	24/7 for 365 days/year; the Hospital does not offer complex ophthalmological surgeries because it does not have the necessary specialized equipment --Oral Surgery: ED physicians on site 24/7 for 365 days/year --Pain Management: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Plastic Surgery: ED physicians on site 24/7 for 365 days/year, and General Surgeons on call 24/7 for 365 days/year --Podiatry: ED physicians on site 24/7 for 365 days/year, Orthopedic Surgeons on call 24/7 for 365 days/year --Psychiatry: Not a service offered by the Hospital because the Hospital does not have a psychiatric unit --Pulmonology: ED physicians on site 24/7 for 365 days/year, Pulmonologists on call 24/7 for 7 days a month, and Internists credentialed to manage patients on ventilators on call 24/7 for most of the remaining 23-24 days per month --Radiation/Oncology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year --Rheumatology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners on call 24/7 for 365 days/year	

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A 459	Continued From page 141 facility. The ED Director stated that she was aware that patients were transferred out of the ED as a result of not having specialty call coverage, and stated that it occurred approximately twice a month to her knowledge, but she only heard about the "particularly messy patients". She stated that the ED physicians complain regularly about the lack of specialty on call coverage, and that they were supposed to be informing the administrator on call every time a patient was transferred to another facility due to no specialist being available to care for the patient, then do an HPRR. The ED Director stated that this issue had been reported to administration, and administration answered, "we're discussing it". She stated that this is a "closed administration at the senior level", and that they don't share information with the management team. The Medical Director of the ED (also a member of the Board of Directors) was interviewed on May 31, 2007, at 1:20 PM. He stated that the voluntary call system was "inconvenient" and that often patients were transferred for the lack of an available specialist. He stated that "It's a problem" and that he had empathy for the patients. He stated the primary issue was customer satisfaction. He stated that although many specialties did not have a physician on-call, Urology was the most common specialty to have nobody who would come in to see a patient. He stated the problem with ventilated patients had improved since Physician D joined the pulmonary/intensive care team. However, he (Physician D) was only on-call one week every four weeks. He stated that the ED physicians are "working with what we have to work with." He further stated that no Quality Assurance/Performance Improvement (QAPI)	A 459	--Urology: ED physicians on site 24/7 for 365 days/year, Internists/Family Practitioners and General Surgeons on call 24/7 for 365 days/year --Vascular Surgery: Covered 24/7 for several days a month by a specific vascular surgeon when scheduled on the Trauma Surgery call panel Administration and ED Physician Leadership developed a grid to facilitate provision of care by on-call specialists and, when a transfer is necessary, to streamline the arrangements for transfer. Specifically, the grid guides ED staff in calling the appropriate on-call specialist for ED patients, and in calling the hospitals capable of furnishing the specialty care that the patient needs and that the Hospital cannot provide at that time. Administration and ED Physician Leadership reviewed and revised the ED on-call list so that all pertinent information about what physicians are on call appears on one page. Administration and the Chair of the PI/RM Committee circulated the grid and revised on-call list to ED staff with a memorandum confirming use of the on-call list and of the grid. Administration clarified that ED staff must contact the appropriate specialist listed on the on-call roster when needed to assess/treat a patient with a possible emergency, rather than calling physicians	07/03/07 07/03/07 07/03/07 07/03/07

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A 459	Continued From page 142 activities were being done to determine the effect the voluntary call system had on patient care, transfers or time spent trying to find a consultant. The Medical Director stated that he spoke at one of the Medical Executive Committee (MEC) meetings, and he told the committee about the difficulty dealing with the voluntary call system; "but until you are in my shoes, looking into the patient's eyes, you cannot know how we (the ED physicians) feel." During a review of ED medical records at RSMC on June 1, 2007, the following was noted: a. Patient 31, an 84 year old male, presented to the ED on April 20, 2007, at 5:57 PM, with a chief complaint of a syncopal (dizzy) episode and a fall. The triage assessment, completed on April 20, 2007, at 6:06 PM, showed that Patient 31 had a hematoma (blood pocket under the skin) above the left eye and on the left forehead, and had a headache. The nurse's notes showed that the patients headache continued throughout the ED stay, and he was medicated on five different occasions for the pain. The ED physician dictated report showed that Patient 31 had a Computerized Tomography (CT) scan of his head, that showed a subdural hematoma (bleeding in the brain) on the right side. The ED physician noted that the facility neurosurgeon was not on call that day, and "he will be transferred for a higher level of care, we do not have a neurosurgeon on call at this time". Patient 31 was transferred to another facility at 9 PM, with a blood pressure of 195/66, accompanied by a critical care transport team, for a "higher level of care". A review of the Medical Staff Roster on May 31,	A 459	who are NOT on call. Administration reviewed and clarified that ED staff should arrange for an appropriate transfer when the appropriate on-call specialist is not available, there is a gap in coverage for the ED, the patient requires services the Hospital does not provide, or the patient needs a higher level of care. ED Leadership met with ED staff to discuss the system for using the on-call list and the grid to obtain appropriate emergency care for ED patients in a timely fashion. The CEO and COO are negotiating a contract for teleneurology to be available to the ED 24/7 for all days where there is no neurology coverage, with a projected launch of the system by sometime in fall 2007. Through teleneurology, the ED will have the benefit of neurologists reading tests and ordering appropriate treatment for neurological problems that require prompt treatment (such as administration of TPA). Administration is negotiating to add interventional cardiology as a Hospital service that would be available to both ED patients and hospital inpatients. Administration has initiated the process for adding a NICU, which would be available to both ED patients and hospital inpatients. The Governing Body reviewed and confirmed that the adoption of the	07/03/07 07/03/07 In process In process Under construction 06/18/07

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A 459	Continued From page 143 2007, showed that the facility had two neurosurgeons on active staff, and only one neurosurgeon was serving on the ED backup call schedule. A review of the April 2007 Emergency Department On-Call Schedule on May 31, 2007, showed that there was a neurosurgeon scheduled to be on call on April 20, 2007. b. Patient 36, a 60 year old male, presented to the ED on April 4, 2007, at 3:47 AM, with a chief complaint of abdominal pain. The ED physician dictated report showed that the patient had a kidney stone on the right side, and needed to be seen by a urologist. The ED physician contacted a urologist on staff at the facility, who did not come in to see Patient 36. Patient 36 was transferred to another facility at 8:50 AM, for urology care. A review of the Medical Staff Roster on May 31, 2007, showed that the facility had six urologists on active staff. A review of the ED on-call schedule on June 1, 2007, showed the urology service ED call listed as "voluntary". c. Patient 40, a 43 year old male, presented to the ED on April 23, 2007, at 10:28 AM, with a chief complaint of sore throat. The ED physician dictated report showed that Patient 40 had a peritonsillar abscess (an abscess around the tonsils), and was having difficulty swallowing. The ED physician noted that he, "discussed transferring the patient for ENT (Ear, Nose and Throat) services, as we have no ear/nose/throat specialist on call today". Patient 40 was	A 459	voluntary call system did not diminish the availability of emergency services to patients. The Governing Body reviewed the overall rate of transfers out of the ED before and after the implementation of the current call system for the ED. Most significantly, the overall rate of transfers (calculated by dividing the number of transfers by the number of emergency visits for each month) has remained essentially the same, and most of the transfers are done because the patients need services the Hospital does not currently provide (such as psychiatry, interventional cardiology, and NICU services). The Governing Body also reviewed and confirmed that the physicians who elect to participate in taking call for the ED are then obligated to respond to calls from the Hospital: --Once a physician volunteers to participate in call, the on-call physician must respond to the ED at least by telephone within 30 minutes of receiving a call, unless the physician is unable to respond for an appropriate reason (i.e., due to circumstances beyond the physician's control, such as the fact that the on-call physician is in emergency surgery for another patient). --If asked, the on-call physician must come to the ED within 30 minutes and provide care to unassigned patients. --If indicated, during the telephone call, the on-call physician can provide	06/18/07

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A 459	Continued From page 144 transferred to another facility at 12 PM for a "higher level of care for ENT services". A review of the Medical Staff Roster on May 31, 2007, showed that the facility had two ophthalmologists on active staff. A review of the ED on-call schedule on June 1, 2007, showed the ophthalmology service ED call listed as "voluntary". d. Patient 203, an elderly female, presented to the ED on May 21, 2007, by ambulance, with a complaint of abdominal pain. The patient had a Computerized Tomography (CT) scan of the abdomen, which was normal. A repeat CT with contrast (used to enhance the image) showed gastritis (inflammation of the stomach). The final diagnoses were Elevated Digoxin Level (a medication used to stimulate a failing heart) and Acute Gastritis. The patient was transferred to another facility for treatment. No documentation was present regarding the reason for transfer. Both of the transfer diagnoses were common medical conditions, usually treated by a cardiologist and a gastroenterologist. Both services were offered at this hospital, however the Gastroenterologists are on a voluntary call schedule for ED back up. e. Patient 204, an elderly female, presented to the ED on May 21, 2007. The physician's notes indicated that she was to be admitted to the telemetry unit with a diagnosis of Cerebral Vascular Accident (CVA, stroke). The nurses notes also stated "Admit to telemetry". Patient 204 was instead transferred to another facility. No documentation was present regarding why the admission was changed to a transfer. A CVA was	A 459	feedback, information, and/or orders to the ED staff to act on while the on-call physician is coming to the ED. For example, when a patient must go to emergency surgery, the Hospital uses the time a surgeon is in transit to the Hospital to gather the OR team and prepare a patient for surgery so there is no delay once the surgeon arrives at the Hospital. Administration provided reminder training to all RN and Respiratory Care Professional staff on the 30 minute response requirement for physicians, how to run the chain of command, and when to complete an HPRR, as described in A 186. The Medical Staff members of the Governing Board drafted and circulated a letter to all Medical Staff members reminding them that they must respond at least by telephone to calls from Hospital staff about their inpatients, and when they are on call for the ED, they must respond by telephone or in person to calls from the ED within 30 minutes, and must come to the ED within 30 minutes when requested. The letter was mailed, faxed, placed in physicians' mailboxes, and posted in all physician areas at both Hospital campuses. Administration reviewed and confirmed several transfer agreements that it has with hospitals to facilitate the transfers of patients from the ED when those facilities are the best facilities available to furnish care the Hospital cannot provide. For example, the Hospital has one transfer	06/29/07 06/21/07 06/25/07

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A 459	Continued From page 145 a common neurological condition, usually treated by a neurologist. The hospital provides neurology services, but the neurology service has a voluntary call schedule for ED back up. f. Patient 205, a young man, presented to the ED on May 5, 2007, with a chief complaint of an eye injury. The ED physician noted that there was a laceration to the upper eyelid that would require the services of a plastic surgeon, a specialty service that is offered at this hospital. However, plastic surgery physicians are on a voluntary call schedule. The patient was transferred to another facility for care. g. Patient 206, a female patient, presented to the ED on May 29, 2007, via paramedics, with a chief complaint of inability to speak and right sided weakness. The ED physician's notes indicated the patient had a probable CVA. This was a common neurological condition usually handled by a neurologist, a service offered at this hospital. Patient 206 was transferred to another facility. The ED physician's notes stated, "We do not have neurology on call." During an interview with the ED Unit Secretary (US) on June 1, 2007, at 10:40 AM, the US stated that when she needed to call a specialty physician, she asked the ED physician or the patient's primary care physician (PCP) which specialist they wanted her to call. She then called that specialist and asked them if they would "consider" taking care of the patient. If the specialist declined, she asked the ED physician or the PCP who to call next, and she continued until she found a specialist that was "willing" to take care of the patient. The US stated that she was "usually" able to find somebody to come in.	A 459	agreement specifically with a children's hospital for pediatric transfers. Administration entered into two additional transfer agreements to facilitate transfers from the ED. ED Leadership is responsible for reviewing a random sample for the timely response to page by the ED call panel physician. Please also see description of monitoring for reason and appropriateness of transfers as described earlier in this tag and under A 456, and for additional actions to monitor physicians' response to calls under A 186. The COO and/or the PI/RM chair are responsible for reporting the analysis of the monitors to the ED Department, the PI/RM Committee, the MEC, and (as indicated) the Governing Body to inform those committees in regularly assessing the appropriateness of on-call coverage for the ED. ALLEGATION OF COMPLIANCE WITH A 459: The Hospital nevertheless respectfully disagrees that it violated the acceptable standards of practice with respect to furnishing on-call coverage for the ED. The citations inappropriately expand the rule when they state, "[T]he facility failed to ensure that Emergency Services were provided in a manner that met the needs of the patients in accordance with acceptable standards of practice for the	06/25/07 07/03/07 & ongoing 07/03/07 & ongoing

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A 459	Continued From page 146 She stated that if they were unable to find a specialist, then the patient got transferred to another facility, but "that doesn't happen very often". During an interview with ED Physician 2 on June 1, 2007, at 11:13 AM, he stated that the voluntary call system "made the job more difficult". ED Physician 2 stated that he had been using the Internal Medicine (IM) or Family Practice (FP) physician for advice on what specialist to call. He stated that it took longer to get a specialist now that it was voluntary, and he had to make multiple calls, but he could usually get somebody to come in.	A 459	provision of on-call physician coverage to the Emergency Department (ED) for services that the facility offered to the public." But that is not the standard established by the Medicare rules. The CoP on Emergency Services states that hospitals "must meet the emergency needs of patients in accordance with acceptable standards of practice." As noted above, the Interpretive Guidelines further clarify that "acceptable standards of practice" include "maintaining compliance with applicable Federal and State laws, regulations, and guidelines regarding hospital emergency services, as well as any standards or recommendations promoted by or established by nationally recognized professional organizations" such as the AMA, ANA, or ACEP. "Acceptable standards of practice" include the EMTALA rules. Neither the Emergency Services CoP nor EMTALA requires ED call coverage for every service a hospital offers, and the 2567 does not cite any other standards that do. In support of the citation, Tag A 459 lists specialties that do not have a call panel, including allergy, dermatology, endocrinology, hematology/oncology, infectious disease, nephrology, podiatry, psychiatry, radiation oncology, rheumatology, and vascular surgery. These examples do not support the finding of a violation for the following reasons:	

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A 459	Continued	A 459	--Many of these listed specialties would never be required to manage an emergency because the ED physicians or more general on-call specialists can handle the emergency. For example, ED physicians regularly treat and stabilize allergic reactions and do not call an allergist. --The Hospital does not offer psychiatric services--it has no psychiatric unit or beds; there is one psychiatrist on staff to provide an occasional consult for an inpatient who has psychiatric problems secondary to the medical issues. --The listing of no vascular surgery call panel indicates the surveyors failed to recognize that one of the two vascular surgeons on staff already participates regularly in the trauma call panel providing emergency coverage for the ED. The Emergency Services CoP further states that there "must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility." This rule likewise does not require 24/7 emergency call coverage for all services offered by the Hospital. CMS recently issued S&C Letter 07-19 on hospital responsibilities for emergency services; that document clarifies that hospitals must "appraise medical emergencies, provide initial treatment and referral when appropriate...." The Hospital meets these requirements as follows:	

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A 459	Continued	A 459	--There is a qualified ED physician on duty at all times in the ED at each hospital campus; --There is a call roster for the ED so that at any given time the ED knows what specialties are covered, and when physicians are on call for the ED, they MUST respond, come to the ED when requested, and provide care to unassigned patients. --The call roster reflects coverage 24/7, nearly 365 days/year by the major specialties needed by ED patients; these include internal medicine/family practice, pediatrics, general surgery, orthopedic surgery, neurosurgery, and cardiology, among others. --The Hospital furnishes 24/7 nursing services and staffs with nurses trained to handle emergencies. Several cases are cited in the 2567 to support the allegation that the Hospital failed to meet the emergency needs of its ED patients. However, instead of showing failure to meet the emergency needs of patients, these cases demonstrate how the Hospital successfully meets the emergency needs of its patients as required under the CoPs. Citing these cases seems to send the message that no patients should EVER be transferred, when the rules clearly permit appropriate transfers and encourage them when they are necessary to assure patients receive the care they need.	

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A 459	Continued	A 459	Patient #36: The record indicates that the patient received an appropriate medical screening examination, and it was determined that the patient had problems with an indwelling catheter, a procedure that had been performed at the VA hospital. The patient had a long history of treatment at the VA hospital for urological problems. The ED physician consulted with a urologist by phone and was able to evaluate and stabilize the patient. The patient was then transferred to the VA Hospital where the patient had undergone the procedure with an indwelling catheter; the transfer was appropriate for continuity of care. Patient #40: The record indicates that this 40-year-old man had a peritonsillar abscess. There was no ENT physician on call at the time. The ED physician attempted to make arrangements for transfer to a hospital with an ENT on call, which was appropriate and reasonable. Patient #105: On March 2, 2007, this patient was sent to the ED by her primary physician for evaluation of possible stroke and was found to have a bleed. The ED physician was able to talk to one of the neurosurgeons on staff regarding options for the patient, but the neurosurgeon was not on call and was out of town that day. It was nevertheless helpful to the ED physician to consult with the neurosurgeon even though the patient needed to be transferred. The ED physician was able to address any emergent needs the patient had and transferred the patient in a stabilized condition to another hospital.	

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A 459	Continued	A 459	Additionally, the hospital implemented nearly 24/7 call coverage for neurosurgery by March 8, 2007, just after this case occurred. Therefore, the hospital appropriately transferred this patient, and then improved the call coverage for neurosurgery well before the survey. Patient #118: This patient was evaluated in the ED for a fracture of his left leg. While there was an orthopedic surgeon on call for the ED that day, the patient requested that the ED physician contact the patient's primary care physician about the case. The patient's primary care physician requested that the patient be transferred to the hospital where the primary care physician had privileges and where the patient could continue to be followed by his regular treating orthopedist. After the ED physician stabilized the patient's fracture, he transferred the patient as requested. Patient #119: A review of the medical record of patient #119 indicates the Hospital met the patient's emergency needs as follows: --Although the patient came in at 1010 on March 27, 2007 having seizures and was diagnosed with Status Epilepticus, the Hospital provided medication so that the LAST documented seizure occurred at 1224, and the patient was alert and interacting by 1354. The transfer did not occur for another 6 hours. --The patient was transferred in a stabilized, nonemergent condition at 1623 to a facility with neurologists available to	

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A 459	Continued	A 459	do a complete workup and address ongoing treatment. The patient was no longer having seizures, and the ambulance transporting the patient had a critical care nurse on board merely as a precaution. Patient #120: The 2567 cites patient #120 as an example of a transfer (a) necessitated because there was not an ophthalmologist on call, and (b) done nearly eight hours after the patient's arrival in the ED. An analysis of the record confirmed that neither conclusion is correct. --The patient would have been transferred even if an ophthalmologist had been available. Because the patient had a possible retinal detachment that could require a complex surgical procedure, and because the Hospital does not have the specialized equipment to do those procedures, the patient was transferred to a tertiary care facility that performs a large number of those procedures. --Additionally, the 2567 states that this patient was transferred at 0743 on April 3, 2007; the medical record documents, however, that the patient left the ED at 0336, about 3 ½ hours after arriving at the ED. Because the patient reported hitting his head, the ED physician had CT scans done of the head and orbits to confirm there were no fractures before arranging a prompt transfer to the tertiary care facility to treat the possible retinal detachment definitively.	

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

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A 459	Continued	A 459	Patient #121: This patient was evaluated in the ED, where the ED staff found no evidence of GI bleeding after inserting a nasogastric tube and having an abdominal CT done. The patient was offered admission but refused and requested transfer to another hospital. This request was honored, and the patient was transferred. Patient #122: This patient came to the ED needing further examination and treatment by an ophtalmologist. Because there was not an opthalmologist on call for the ED, the patient was appropriate stabilized and transferred to another hospital. Patient #124: This patient was evaluated in the ED and required inpatient admission related to acute renal failure and anemia. However, the patient required care in a pediatric ICU, which the Hospital does not have. Arrangements were made to transfer the patient to a Hospital with a Pediatric ICU that could provide the services required by the patient. Patient #203: This patient was evaluated for abdominal pain; the first CT scan came back negative, and the second CT scan indicated gastritis. This patient was transferred to another hospital because her primary physician was not on staff at the Hospital. The ED made sure the patient was not in an emergent state, and then transferred her in a stable condition to a hospital where her physician had privileges.	

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A 459	Continued	A 459	Patient # 204: The report incorrectly reports what occurred with this patient. This patient was not transferred. She was admitted to the Hospital. After discussions concerning possible nursing home placement, the patient chose to be discharged home, and the discharge took place the day after admission. Patient #205: This patient was appropriately evaluated in the ED. The patient needed plastic surgery to repair a laceration to his eyelid. However, there were no plastic surgeons on call at the time he presented. The Hospital made arrangements for an appropriate transfer to another hospital that had plastic surgery capability. Patient # 206: An ambulance brought this patient to the ED with possible CVA. The patient was appropriately evaluated. and it was determined that the patient needed to be admitted. Because the patient's primary care physician had privileges at another hospital, the patient requested transfer to that hospital. The patient was transferred after being stabilized. For these reasons, the Hospital submits that the Hospital was and is in compliance with the rules; that this citation should be removed; and that the entire 2567 should be withdrawn.	