

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

PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2011
NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM			STREET ADDRESS, CITY, STATE, ZIP CODE 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 450	<p>Continued From page 75 facility:</p> <p>1. Failed to ensure perinatal medical screening exams (MSE) and nonstress tests (NST) were evaluated by the physicians, and the outpatient records were signed by the physicians per facility policies and procedures for four of 73 sampled patients, (Patients 51, 52, 56, and 57). This failed practice prevented the physician from authenticating the perinatal outpatient records and evaluating the services provided by the nurse for a MSE or NST.</p> <p>2. Failed to ensure the physician's orders were noted "promptly" by the nurse per facility policy and procedure for one of 73 sampled patients (Patient 53). This failed practice had the potential to delay care to Patient 53 as ordered by the physician.</p> <p>Findings:</p> <p>1a. On July 28, 2011, the medical record for Patient 51 was reviewed. Patient 51 was seen as an outpatient in the labor and delivery department on ten occasions from [REDACTED] 2011. The "OB Outpatient Record" was reviewed for each visit. The documents indicated a medical screening exam was completed by an RN on each visit. One of ten visits, dated June 14, 2011, was signed by the physician within 48 hours to authenticate the physicians review and approval of the medical screening exam completed by the RN. Two of ten visits, dated May 4 and June 24, 2011, were signed by a physician, but not within the required 48 hours after the examination was completed. Seven visits, dated April 28, June 3, 4, 25, July 6 and 12, 2011, did not contain a</p>	A 450	<p>Continued From page 75</p> <p>Findings 1a-d:</p> <p>Actions Taken:</p> <p>1. The CMO, OB/GYN Department Chair and Chief of Staff met to discuss the survey findings. 8/30/11</p> <p>2. The Chief of Staff talked with the OB/GYN medical staff members regarding their responsibility to evaluate perinatal medical screening exams (MSE) and nonstress tests (NST) and to timely authenticate the outpatient records. 8/30/11</p> <p>3. The Chief of Staff drafted a letter, approved by the OB/GYN Department Chair, to all OB/GYN medical staff members reminding them of the Hospital's policy to review and sign NSTs within 24 hours and MSE's within 48 hours and that noncompliance may lead to</p> <p>8/11/11</p>	

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A 450	<p>Continued From page 76</p> <p>physician signature to authenticate the medical screening exam.</p> <p>The fetal monitoring strips were reviewed for all ten visits. None of the fetal monitoring strips were signed by the physician to indicate review and approval of the medical screening exams by the RN.</p> <p>The electronic nursing documentation was reviewed for all ten visits. There was no electronic signature by the physician to indicate review and approval of the medical screening exams by the RN.</p> <p>b. On July 28, 2011, the medical record for Patient 52 was reviewed. Patient 52 was seen as an outpatient in the labor and delivery department on three occasions on May 19, June 8, and 10, 2011. The "OB Outpatient Record" was reviewed for each visit. The documents indicated a medical screening exam was completed by a RN on each visit. All three medical screening exams were not signed by the physician to authenticate the physicians review and approval of the medical screening exam completed by the RN.</p> <p>The fetal monitoring strips were reviewed for all three visits. None of the fetal monitoring strips were signed by the physician to indicate review and approval of the medical screening exams by the RN.</p> <p>The electronic nursing documentation was reviewed for all three visits. There was no electronic signature by the physician to indicate review and approval of the medical screening exams by the RN.</p>	A 450	<p>Continued From page 76</p> <p>suspension of medical staff privileges for incomplete medical records in accordance with the medical staff bylaws.</p> <p>4. The Director of HIM initiated a process to create a DF file of Fetal Heart Tracing (NST) and the MSE record that are uploaded into the "Document Imaging" system (DI, digital medical record scanning program) giving remote access to the physician to review the NST, enter comments if necessary, and provide electronic signatures on the NST and MSE. The Director of HIM or staff will also contact the physician when their review has noted a missing physician signature. Any issues will be reported to the CMO and OB/GYN Department Chair for further 1:1 follow up with the physician as necessary.</p> <p>Compliance and Monitoring:</p> <p>The HIM Director will perform a concurrent medical record review of 50 records a month for 3 months (and then re-evaluate) to achieve a goal of 100% compliance with physician evaluation and authentication of MSE and NSTs. Corrective action is taken as necessary. The HIM Director reports on compliance bimonthly to the OB/GYN Medical Staff committee, who will report compliance through the hospital Quality Oversight Structure to the MEC and the Board of Governors.</p> <p>Persons Responsible:</p> <p>HIM Director CMO OB/GYN Department Chair</p>	8/30/11 9/6/11 and ongoing

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A 450	<p>Continued From page 77</p> <p>c. On July 26, 2011, the records for Patient 56 were reviewed. Patient 56 was seen as an outpatient in the labor and delivery department on [REDACTED] 2011, and [REDACTED] 2011. The "OB Outpatient Record," "Nursing Flowsheets," and fetal monitoring strips were reviewed for each visit. The documents indicated a medical screening examination was completed by a perinatal nurse on each visit. There was no indication the physician had evaluated the written outpatient records and fetal monitor strips by signing the "OB Outpatient Record."</p> <p>d. On July 26, 2011, the records for Patient 57 were reviewed. Patient 57 was seen as an outpatient in the labor and delivery department for a medical screening exam (MSE) on [REDACTED] and 11, 2011, and for nonstress testing (NST) on May [REDACTED], 2011. The "OB Outpatient Record," "Nursing Flowsheets," and fetal monitoring strips were reviewed for MSE visits. The documents indicated a medical screening examination was completed by a perinatal nurse on each visit. There was no indication the physician had evaluated the written outpatient records and fetal monitor strips by signing the "OB Outpatient Record."</p> <p>The "Nursing Flowsheets" and fetal monitoring strips were reviewed for each NST visit. The documents indicated a nonstress test was completed by a perinatal nurse on each visit. There was no indication the physician had reviewed and initialed the fetal monitoring strips in either writing or electronically.</p> <p>On July 27, 2011, at 2:15 p.m., an interview was conducted with the Director of Health Information</p>	A 450		

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A 450	<p>Continued From page 78</p> <p>Management (DHIM), Nurse Manager (NM 2), and Educator 1. They stated the physician was supposed to sign the outpatient record. In addition, they stated the physician should sign a NST within 24 hours of the test occurring and authenticate a medical screening exam performed by a perinatal nurse within 48 hours of the examination occurring.</p> <p>On July 27, 2011, at 3:30 p.m., an interview was conducted with Health Information Management Coordinator (HIMC 1). She stated for the perinatal outpatient records, HIM flags the physician's orders and progress notes, if there were any. In addition, she stated HIM did not flag the "OB Outpatient Record" or the fetal monitor strips for the physician's signature.</p> <p>During an interview with Educator 1, on July 27, 2011, at 4:30 p.m., she reviewed the clinical records for Patients 56 and 57, and she was not able to find documentation (for the 11 outpatient visits) that the physicians had reviewed and initialed the fetal monitor strips for nonstress testing outpatient visits or had evaluated the written outpatient record and fetal monitor strips by signing the "OB Outpatient Record" for MSE visits.</p> <p>The facility "Medical Staff Bylaws 2011" dated June 23, 2011, indicated "Basic Responsibilities of Medical Staff Membership ... (b) abiding by the Medical Staff bylaws, Medical Staff rules and regulations, and policies and Medical-Staff approved Hospital policies and procedures, ... (d) preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the Hospital ..."</p>	A 450		

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A 450	<p>Continued From page 79</p> <p>The facility policy and procedure titled "Standardized Procedure: EMTALA-2-Perinatal Medical Screening Exam" reviewed July 2011, indicated "... The primary physician shall evaluate the written outpatient record and any fetal monitor strips obtained during the observation period. The physician will countersign his telephone orders and sign the outpatient record. ..."</p> <p>The facility policy and procedure titled "Nonstress Test" dated November 2010, indicated "... The physician must review and initial the NST within twenty-four (24) hours of completion of the test. This may be done remotely via the electronic documentation system (OBTVUE). ..."</p> <p>2. On July 26, 2011, the record for Patient 53 was reviewed. Patient 53 was admitted to the facility on [REDACTED] 2011, with diagnosis of surgical laparoscopic hysterectomy (removal of the uterus through an abdominal scope).</p> <p>The "Medication Reconciliation Admission Orders, Inpatient" dated July 25, 2011, at 9:40 a.m., indicated Claritin 20 mg po (by mouth) daily for allergies, Robitussin DM "UR (unable to recall dose)" po prn (as needed) for allergies, and Pepcid "UR" po prn for indigestion, and the three boxes for "Continue Medication" were checked "Yes." RN 3 "noted" the order on June 25, 2011, at 5 p.m.</p> <p>The "Medication Administration Record (MAR)" dated July 25, 2011, did not indicate the three medications were available for administration to Patient 53.</p>	A 450	<p>Continued From page 77</p> <p>Finding 2:</p> <p>Actions Taken:</p> <ol style="list-style-type: none"> 1. Nursing Leadership met with the Clinical Managers to discuss the survey finding regarding nurses promptly noting physician orders and the Physician's Orders policy. 2. Nurses were inserviced on promptly noting physician orders so as to ensure the timely execution of the order. <p>Compliance and Monitoring:</p> <p>The CNO or qualified designee will perform a concurrent medical record review of 50 records a month for 3 months (and then re-evaluate) to achieve a goal of 100% compliance with timely noting physician orders. Corrective action is taken as necessary. The CNO reports on compliance monthly to the hospital PI Council, who will report through the hospital Quality Oversight Structure to the Board of Governors monthly.</p>	<p>8/10/11</p> <p>9/6/11</p> <p>9/6/11 and ongoing</p>

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A 450	Continued From page 80 On July 26, 2011, at 1:10 p.m., an interview was conducted with RN 3 and RN 4. They stated when a physician's medication order was written, the record with the order went to the unit secretary who "scanned" the medication orders to the pharmacy. They stated the record then went to the charge nurse, or the patient's nurse, who "noted" the orders and wrote the medication order on the MAR. In addition, RN 3 and RN 4 stated "a nurse should note physician's orders within two hours of the time they were written." The facility policy and procedure titled "Physician's Orders" reviewed December 2010, indicated "To establish guidelines for obtaining and processing physician's orders to ensure prompt quality patient care is provided. ... Physician's orders will be accurately processed and promptly followed. ... Written orders will be transcribed and implemented promptly. ... If the order is not complete, the ordering physician will be called to clarify the order. ..."	A 450	Continued From page 80 Person Responsible: CNO		
A 457	482.24(c)(1)(iii) VERBAL ORDERS AUTHENTICATED BASED ON LAW All verbal orders must be authenticated based upon Federal and State law. If there is no State law that designates a specific timeframe for the authentication of verbal orders, verbal orders must be authenticated within 48 hours. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure telephone/verbal orders were authenticated within 48 hours for 6 of 73 sampled patients, (Patients 7, 17, 51, 52, 56 and 57). This failed practice could potentially result in errors with medication management or a delay in	A 457	482.24(c)(1)(iii) VERBAL ORDERS AUTHENTICATED BASED ON LAW		

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A 457	<p>Continued From page 81 treatment and care to the patient.</p> <p>Findings:</p> <p>1. During a review of the medical record of Patient 7 on July 25, 2011, the file contained a form titled, "Outpatient Observation Orders." The pre-printed form had orders for performing a sterile vaginal exam to determine cervical status, and an order for PO (oral) hydration. The telephone orders were dated July 22, 2011, at 7 p.m., but the physician did not sign them until July 25, 2011, at 8 a.m., 59 hours later.</p> <p>During an interview with the CMO on July 25, 2011, at 10 a.m., he looked at the Outpatient Observation Orders of Patient 7 and concurred that the orders had not been signed within 48 hours and that the policy was for the physician to sign within 48 hours.</p> <p>The facility policy, "Physician's Orders" (revised March, 2010), was reviewed on July 28, 2011. The policy read in part, "Verbal/Telephone orders are to be authenticated within 48 hours by the physician giving the order."</p> <p>2. A review of Patient 17's record was conducted on July 25, 2011. Patient 17 was admitted to the facility on [REDACTED] 2011, with a diagnosis of [REDACTED]</p> <p>There was no physician authentication completed within 48 hours on the following seven dates and times when a verbal/telephone order was received from the physician by the licensed nurse;</p>	A 457	<p>Continued From page 81</p> <p>Actions Taken:</p> <p>1. Administration, Nursing Leadership, Director of HIM, and the Chief of Staff met to discuss the issues of authenticating verbal orders within 48 hours. This issue was also presented to the MEC and Governing Board. The CMO sent a letter to all physicians regarding the Hospital's expectation that physicians will comply with authenticating orders within 48 hours. Continued noncompliance may result in suspension of clinical privileges for incomplete medical records in accordance with the Medical Staff Bylaws.</p> <p>2. The hospital's medical records staff will review patients' open records on a daily basis for completion of authenticating telephone/verbal orders. Incomplete orders are flagged and each physician is assigned a color coded tag. A legend is placed in the front of the chart to inform the physician what color they are assigned. The HIM staff assists the unit secretary to notify the physicians while on the nursing units.</p> <p>3. The HIM Department shall provide a report to all medical staff departments at each regularly scheduled meeting and the Department Chair will discuss the issue with physicians. The Chief of Staff and Department Chair will have a 1:1 discussion with physicians who fail to authenticate their orders timely.</p> <p>4. The issue of authenticating verbal orders is a standing agenda item at the quarterly medical staff meetings. The Chief of Staff will continue to educate and enforce physician compliance.</p> <p>5. The issue of authenticating verbal orders is a standing agenda item at the Patient Safety Committee.</p>	<p>9/6/11</p> <p>8/1/11</p> <p>8/30/11</p> <p>9/1/11</p> <p>9/1/11</p>	

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A 457	<p>Continued From page 82</p> <p>July 14, 2011, 2:40 p.m., July 16, 2011, 9:30 p.m., July 17, 2011, 8:30 a.m., July 17, 2011, 11:30 a.m., July 17, 2011, 7:33 p.m., July 18, 2011, at 4:30 p.m., and July 21, 2011, 11:30 a.m.</p> <p>A review of the facility policy, "Clinical Practice Providing Care (Title: Physician's Orders (Reviewed 12/2010)," indicated, "Verbal/Telephone orders are to be authenticated within 48 hours by the physician giving the order."</p> <p>An interview was conducted with the Nurse Manager (NM 3) on July 25, 2011, at 2:30 p.m., who stated physician's orders need to be signed within 48 hours.</p> <p>3. Patient 51 was seen as an outpatient at the IVMC Women's Center on ten occasions from April 28 through July 12, 2011. Patient 51 was evaluated by a RN, who called the physician after the examination and received telephone orders. During a review of the physician orders of the outpatient visits, the following was noted:</p> <p>i. An "Outpatient Physician Orders" sheet for an outpatient visit dated April 28, 2011, was electronically signed by the physician on May 9, 2011. The signature was made 11 days after the outpatient visit.</p> <p>ii. An "Outpatient Physician Orders" sheet for an outpatient visit dated May 4, 2011, was electronically signed by the physician on May 22, 2011. The signature was made 18 days after the outpatient visit.</p>	A 457	<p>Continued From page 82</p> <p>Compliance and Monitoring:</p> <p>The HIM Director or designee shall audit charts concurrently to ensure compliance for three months (and then re-evaluate) to achieve the goal of 100% compliance with physicians timely authenticating orders. The Chief of Staff shall be notified monthly of noncompliance so that corrective action may be taken. The Chief of Staff shall report on compliance to the MEC and hospital PI Council on a monthly basis, who will report through the hospital Quality Oversight Structure to the Board of Governors monthly.</p> <p>Persons Responsible:</p> <p>HIM Director CMO Chief of Staff</p>	9/6/11 and ongoing

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A 457	<p>Continued From page 83</p> <p>iii. An "Outpatient Physician Orders" sheet for an outpatient visit dated May 21, 2011, was electronically signed by the physician on May 31, 2011. The signature was made 10 days after the outpatient visit.</p> <p>iv. An "Outpatient Observation Orders" sheet for an outpatient visit dated June 3, 2011, was electronically signed by the physician on June 13, 2011. The signature was made eight days after the outpatient visit.</p> <p>v. An "Outpatient Observation Orders" sheet and a "Physician's Order Sheet" dated June 4, 2011, were electronically signed by the physician on June 13, 2011. The signature was made nine days after the outpatient visit.</p> <p>vi. An "Outpatient Observation Orders" sheet dated June 14, 2011, was electronically signed by the physician on June 23, 2011. The signature was made nine days after the outpatient visit.</p> <p>vii. An "Outpatient Observation Orders" sheet dated June 25, 2011, was electronically signed by the physician on July 11, 2011. The signature was made 16 days after the outpatient visit.</p> <p>viii. An "Outpatient Observation Orders" sheet, "Discharge Orders" dated June 26, 2011, had an electronic signature by the physician on July 11, 2011. The signature was made 15 days after the outpatient visit.</p> <p>The admission portion of the "Outpatient Observation Orders" and an "Outpatient Medication Reconciliation and Physician's Order" sheet dated June 26, 2011, were not signed by the physician.</p>	A 457			

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A 457	Continued From page 84 ix. An "Outpatient Observation Orders" sheet dated July 6, 2011, was electronically signed by the physician on July 20, 2011. The signature was made 14 days after the outpatient visit. The "Discharge Orders" and an "Outpatient Medication Reconciliation and Physician Orders" sheet dated July 6, 2011, were not signed by the physician. x. An "Outpatient Observation Orders, Discharge Orders" dated July 12, 2011, was electronically signed by the physician on July 22, 2011. The signature was made 14 days after the outpatient visit. The admission portion of the form did contain orders for fetal monitoring and PO hydration, but there was no signature for the admission orders by the nurse or physician. An "Outpatient Medication Reconciliation and Physician's Order" dated July 12, 2011, was not signed by the physician. 4. Patient 52 was seen as an outpatient at the IVMC Women's Center on three occasions from [REDACTED] through [REDACTED] 2011. Patient 52 was evaluated by a RN, who called the physician after the examination and received telephone orders. During a review of the physician orders of the outpatient visits, the following was noted: i. An "Outpatient Physician Orders" sheet and a "Physician's Order Sheet dated May 19, 2011, was electronically signed by the physician on June 15, 2011. The electronic signature was made 27 days after the outpatient visit. ii. An "Outpatient Observation Orders" sheet and	A 457			

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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 457	<p>Continued From page 85</p> <p>a "Physician's Order Sheet dated June 9, 2011, were electronically signed by the physician on June 28, 2011. The electronic signature was 19 days after the outpatient visit.</p> <p>An "Outpatient Medication Reconciliation and Physician's Order" sheet dated June 9, 2011, was not signed by the physician.</p> <p>iii. An "Outpatient Observation Orders" sheet and a "Physician Order Sheet dated June 10, 2011, was electronically signed by the physician on June 28, 2011. The electronic signature was 18 days after the outpatient visit.</p> <p>An "Outpatient Medication Reconciliation and Physician's Order " sheet dated June 9, 2011, was not signed by the physician.</p> <p>5. On July 26, 2011, the records for Patient 56 were reviewed. Patient 56 was seen as an outpatient in the labor and delivery department on [REDACTED] 2011, for vaginal bleeding and on [REDACTED] 2011, for premature labor (contractions prior to the 37th week of pregnancy).</p> <p>There was no physician authentication completed for verbal/telephone orders received by the RN from the physician on the following dates and times within 48 hours:</p> <p>June 7, 2011, at 9:50 p.m. - Outpatient Observation Orders; June 7, 2011, at 9:50 p.m. - Discharge Orders; and July 16, 2011, at 5:20 p.m. - Discharge Orders.</p> <p>6. On July 26, 2011, the records for Patient 57 were reviewed. Patient 57 was seen as an outpatient in the labor and delivery department</p>	A 457			

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

PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2011
NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM			STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562	
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A 457	<p>Continued From page 86</p> <p>on:</p> <p>██████████ 2011, for premature contractions;</p> <p>██████████ 2011, for mild contractions, nonstress testing (monitoring to aid in the determination of fetal well-being) and administration of betamethasone (a medication used to mature fetal lungs);</p> <p>██████████ 2011, for fetal monitoring;</p> <p>██████████ 2011, for nonstress testing (NST) for preterm labor;</p> <p>██████████ 2011, for NST for preterm labor; and</p> <p>██████████ 2011, for NST for preterm labor.</p> <p>There was no physician authentication completed for verbal/telephone orders received by the RN from the physician on the following dates and times within 48 hours:</p> <p>May 8, 2011, at 10:18 a.m.;</p> <p>May 8, 2011, at 12:40 p.m.;</p> <p>May 8, 2011, at 2:42 p.m.;</p> <p>May 8, 2011, at 3:57 p.m.;</p> <p>May 11, 2011, at 12:00 p.m.;</p> <p>May 11, 2011, at 1:29 p.m.;</p> <p>May 11, 2011, at 2:15 p.m.;</p> <p>May 12, 2011, at 3:25 p.m. (testing orders);</p> <p>May 12, 2011, at 3:25 p.m. (discharge orders);</p> <p>May 16, 2011, at 9:34 a.m.;</p> <p>May 19, 2011, at 9:30 a.m.;</p> <p>May 23, 2011, at 10 a.m.;</p> <p>May 27, 2011, at 11:20 a.m.;</p> <p>May 30, 2011, at 4:36 p.m. (Outpatient Observation Orders);</p> <p>May 30, 2011, at 4:36 p.m. (Discharge Orders);</p> <p>June 3, 2011, at 4:10 p.m.; and</p>	A 457		

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

PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2011
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A 457	Continued From page 87 June 3, 2011, at 5:30 p.m. On July 27, 2011, at 2:20 p.m., an interview was conducted with the Director Health Information Management (DHIM). She stated the physicians were supposed to authenticate their telephone and verbal orders within 48 hours of the time the order was written. The "Medical Staff Rules and Regulations" dated July 28, 2011, indicated "... Verbal Orders ... The responsible practitioner shall countersign, date and time the order within 48 hours from the time the order was written. ..." 6. During a review of the medical record of Patient 7 on July 25, 2011, the file contained a form titled, "Outpatient Observation Orders." The pre-printed form had orders for performing a sterile vaginal exam to determine cervical status, and an order for PO (oral) hydration. The telephone orders were dated July 22, 2011, at 7 p.m., but the physician did not sign them until July 25, 2011, at 8 a.m., 59 hours later. During an interview with the CMO on July 25, 2011, at 10 a.m., he looked at the Outpatient Observation Orders of Patient 7 and concurred that the orders had not been signed within 48 hours and that the policy was for the physician to sign within 48 hours. The facility policy, "Physician's Orders" (revised 3/2010), was reviewed on July 28, 2011. The policy read in part, "Verbal/Telephone orders are to be authenticated within 48 hours by the physician giving the order."	A 457			
A 490	482.25 PHARMACEUTICAL SERVICES	A 490	482.25 PHARMACEUTICAL SERVICES		

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

PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM			STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562		
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A 490	<p>Continued From page 88</p> <p>The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.</p> <p>This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide pharmaceutical services that meet the needs of the patients as evidenced by the facility's failure to:</p> <ol style="list-style-type: none"> 1. Maintain and implement a system with accurate records of receipt and disposition capable of readily identifying diversion of all controlled substances in such a manner as to minimize the extent of diversion. (A494) 2a. Conduct monthly audit of the Drug Diversion Report in accordance with the facility's policy and procedure; b. Conduct monthly audit of Drug Diversion Report using Standard Deviation (SD) greater than two instead of three in accordance with the facility's policy and procedure; c. Conduct review of controlled substance wastage in accordance with the facility's policy and procedure; and, d. Conduct review of manual entry of ED patients for potentially inappropriate access to controlled substances by caregivers in accordance with the facility's policy and procedure. (A500) 3. Address potential delay in timely administration 	A 490	<p>Continued From page 88</p> <p>Hospital leadership met with the Pharmacy Director to discuss the survey findings and strongly emphasized the expectation that the pharmacy maintain ongoing compliance with the Pharmacy Conditions of Participation. The Pharmacy Director reviewed the Controlled Substances, Automated Drug Dispensing System and Controlled Substances: Procedure for Theft/Loss policies and procedures. Pharmacy Managers were inserviced on all policies related to controlled substances, with special emphasis on maintaining accurate records to readily identify drug diversion in accordance with hospital policy, properly conducting monthly audits of the Drug Diversion reports, reviewing controlled substance wastage, and reviewing manual entry into the Pyxis machine for potentially inappropriate access to controlled substances. The Pharmacy Director revised the crash cart list to include Atropine 0.4mg/ml x 4 and increased the allotment of sterile water for Dantrolene preparation on the Malignant Hyperthermia Cart. Nursing and pharmacy staff was inserviced on the importance of medication delivery and communication between the departments. When the order is transcribed, if the physician order does not contain all required elements for a complete medication order, at that time, the nurse shall call the physician to clarify the order. When the pharmacy receives an incomplete medication order, the Pharmacist immediately takes action to clarify the order by contacting the nurse and/or the physician. The Pharmacist reviews the pending order queue at the beginning of each shift and periodically throughout the shift. The Pharmacist will continue to follow-up on any outstanding medication orders with the nurse and/or the physician to obtain the necessary information to ensure medication administration is performed in a safe and</p>	9/6/11	

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

PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2011
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A 490	Continued From page 89 of medications caused by missing documentation of communication within pharmacy and other departments. (A500) 4. Have enough sterile water to mix the 36 vials of dantrolene 20 mg during an emergency. (A500) 5. Update the facility's policy and procedure that reflected the content of the Adult Crash Cart. (A500) 6. Conduct the annual review of the hospital formulary in accordance with the facility's policy and procedure. (A500) 7. Ensure an unusable medication was not available for patient use. (A505) The cumulative effect of the systemic problems resulted in the hospital's failure to ensure the provision of pharmaceutical services in a safe environment that met the needs of the patients.	A 490	Continued From page 89 effective manner. Review of the hospital's formulary is performed annually and is identified as a standing agenda item at the P&T Committee. In addition, the Pharmacy Director reinserviced all pharmacy staff on the use of single dose vials. The Pharmacy Director shall report monthly to Administration on the status of pharmacy operations and compliance with issues identified in the survey findings for six months and then it will be re-evaluated. Compliance and Monitoring: The Pharmacy Director shall report bimonthly to P&T on the status of pharmacy operations and compliance with issues identified in the survey findings who will report through the hospital Quality Oversight Structure to the Board of Governors monthly for six months and then it will be re-evaluated. Persons Responsible: Pharmacy Director CNO	9/6/11 and ongoing	
A 494	482.25(a)(3) PHARMACY DRUG RECORDS Current and accurate records must be kept of the receipt and distribution of all scheduled drugs. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain and implement a system with accurate records of receipt and disposition, capable of readily identifying diversion (unapproved removal and/or use) of all controlled substances in such a manner as to minimize the extent of the diversion.	A 494	482.25(a)(3) PHARMACY DRUG RECORDS Action Taken 1. The CNO met with the Pharmacy Director to discuss the survey findings. The Pharmacy Director will be required to submit monthly reports to the CNO regarding compliance with the hospital's policies regarding controlled substances. 2. The Pharmacy Director reviewed all existing policies and procedures relating to maintaining and implementing the pharmacy's system for readily identifying drug diversion of controlled substances. The Pharmacy Director inserviced pharmacy managers on the policies related to monitoring for drug diversion of controlled	7/27/11 9/6/11	

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

PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391

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A 494	<p>Continued From page 90</p> <p>Findings:</p> <p>During an interview on July 27, 2011, at 4 p.m., Nurse Manager (NM 6) stated that there were two incidences of controlled substance drug diversion that were identified and investigated that involved two Registered Nurses (RN 15 and RN 16) that worked in the Emergency Department (ED).</p> <p>NM 6 stated a patient (Patient 74), who was admitted to the hospital through the ED reported that the pain medications the patient received while in ED administered by RN 15 were not as effective as the pain medications received while in the inpatient nursing unit. This prompted an investigation that led to the identification of RN 15 diverting controlled substances.</p> <p>According to the electronic mail (e-mail) sent to several of the facility's leadership members dated July 14, 2011, by NM 6,</p> <p>"I received a patient complaint regarding (RN 15)'s care. The patient stated that she was cold and needed blankets but (RN 15) did not provide them. That her pain was uncontrolled for several hours, (RN 15) did not introduce herself or explain what she was doing, was rude and condescending, and the environment was dirty. The patient stated that she did not feel the effects of the morphine (narcotic pain medication) that (RN 15) gave her, but did feel the effects of morphine that other nurses gave her. These complaints prompted me to review (RN 15)'s narcotic activity for five 12 hour shifts ..."</p> <p>NM 6's investigation of narcotic activity from July 3, 2011, to July 11, 2011, revealed that RN 15</p>	A 494	<p>Continued From page 90</p> <p>substances, including investigating reports of potential drug diversion, monitoring the automated drug dispensing system for discrepancies and inappropriate manual overrides, and generating accurate and complete monthly diversion reports. Pharmacy Managers will complete reviews of controlled substance access at least weekly, to proactively discover any diversion possibilities. Reviews may include Override report, Discrepancy report, Return and Waste report, Removal of controlled substance compared to order and Standard Deviation report. Pharmacy Managers will send a notice of irregularities (the PYXIS Controlled Substance Discrepancy form and any other pertinent information) to the Nurse Manager. The Nurse Manager will investigate each incident, document the investigation and actions taken on the PYXIS Controlled Substance Discrepancy form, and return the document to the Pharmacy Manager. Pharmacy and Nursing Leadership will discuss the findings and take actions as necessary. If there is a suspected diversion, the Pharmacy Director is contacted immediately and oversees the investigation. The Pharmacy Director is ultimately responsible for ensuring that: a) controlled substances are monitored; b) accurate records are maintained in accordance with Hospital policies and procedures; c) thorough and complete investigations are performed; and d) necessary corrective action is taken. The Pharmacy Director is also ultimately responsible for ensuring collaborative efforts by both the Pharmacy and Nursing Departments in investigating irregularities concerning controlled substances.</p> <p>3. The Pharmacy Director clarified who is able to manually enter patients into the Pyxis MedStation. All nurses are allowed to</p>	8/15/11

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

PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2011
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A 494	<p>Continued From page 91</p> <p>accessed, from the Pyxis MedStation (automated drug dispensing cabinet: ADC) in ED, three 1 mg injectable Dilaudid (narcotic pain medication) without physician orders, two 0.5 mg doses from 1 mg injectable Dilaudid without documented wastage, and two doses of injectable morphine (one 4 mg and one 8 mg dose) from which the patient did not feel the effect.</p> <p>NM 6 stated that RN 15 started on June 29, 2011, and her last day was July 12, 2011.</p> <p>During the same interview with NM 6, she stated that an investigation and identification of drug diversion occurred for RN 16 due to the report from the Charge Nurse on June 30, 2011, that RN 16, while on duty in the ED, was observed by ED staff in the ED nurse's lounge, during work hours, to be behaving strangely, and looked, "spaced out."</p> <p>NM 6's investigation of RN 16's narcotic activity spanned from June 29 and June 30, 2011, revealed that RN 16 accessed from the Pyxis MedStation in ED thirteen doses of 2 mg injectable Dilaudid without physician orders, two 1 mg doses and one 0.5 mg dose from 2 mg injectable Dilaudid without documented wastage.</p> <p>During an interview on July 27, 2011, at 1:40 p.m., the DP stated that she was informed of the two drug diversion cases by NM 6 who requested the narcotic activity report from the Pharmacy. The DP stated that she provided NM 6 the reports printed from the Pyxis Reporter that listed high users of controlled substances and the patient names from CareFusion (Pyxis analytics software that provides statistics and analysis).</p>	A 494	<p>Continued From page 91</p> <p>manually enter patients. Pharmacists shall review the "Entered ADT Information" on a daily basis to review the list of patients that were manually entered and compare it to the medications ordered and signed out to the patient. The Pharmacy Director shall be notified immediately of any inconsistencies and an investigation shall be initiated. The Pharmacy Director shall also communicate any issues with the Clinical Manager.</p> <p>4. The Pharmacy Director completed an investigation into RN 15's and 16's use of controlled substances and conveyed the findings to the Nursing Manager and CNO.</p> <p>5. The Pharmacy Director completed a monthly audit of Drug Diversion report using a standard deviation of 2 on all units from January 2011 through July 2011. There were no inconsistencies identified.</p> <p>Compliance and Monitoring:</p> <p>The Pharmacy Director shall perform a monthly review of pharmacy records for six months (and then re-evaluate) to achieve a goal of 100% compliance with maintaining current and accurate records regarding controlled substances and performing investigations as necessary. The Pharmacy Director is required to submit a monthly report to the CNO for six months and then it will be re-evaluated. Corrective action shall be taken if needed. The CNO or qualified designee shall report on compliance monthly to the hospital Patient Safety Council, who will report through the hospital Quality Oversight Structure to the Board of Governors monthly.</p> <p>Persons Responsible:</p> <p>Pharmacy Director CNO</p>	7/28/11 7/30/11 9/6/11 and ongoing

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

PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2011
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A 494	Continued From page 92 The DP stated the investigation was conducted by NM 6 and there was no further investigation done by the Pharmacy. When asked about the narrow time frame of narcotic activity by the two RNs reviewed by NM 6, the DP acknowledged that the investigation could have been more thorough. Review of the facility's policy and procedure titled, "Automated Drug Dispensing Systems" revealed the following: "K. Reports. 1. Open Discrepancies: Will be used to ensure that all discrepancies are resolved in a timely manner ... 2. Discrepancy Report: Will be used by the unit charge nurses to verify with the following shift unit charge nurse that there are no unresolved discrepancies ... 4. Profile Override: Will be used to verify that all medications that were obtained from the Pyxis MedStation (Automated Drug dispensing Cabinet: ADC) via "override" have an order written and entered into the pharmacy computer system. 5. Diversion Reports: a. Will be generated monthly by the Pharmacy Managers documenting employees that show 2 or more standard deviations over the average removal rate of controlled substances for a particular nursing unit. b. The report will be distributed to the Nurse Managers for review, investigation and follow up. c. The Nursing Manager will state whether there is further study indicated or no further analysis is required and all data checks out and return the report to the Director of Pharmacy."	A 494		

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

PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2011
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A 494	<p>Continued From page 93</p> <p>During the same interview, the DP acknowledged that she did not know that the monthly diversion reports had to be generated using the standard deviation (SD) of greater than 2 rather than 3. Standard Deviation (SD) - is a measurement calculation used to show how much variation there is from the average amount. Using the standard deviation number of 3, instead of the number required in the facility policy which is 2, caused the facility to miss the deviations that would've been on the report had they followed their policy.</p> <p>During an interview on July 27, 2011, at 2 p.m., Pharmacist 1 stated that the monthly diversion reports were run using SD greater than 3 since July 2010, and the SD greater than 3 had been used because it was the system default and admitted he was not able to change the parameters.</p> <p>When Pharmacist 1 was able to run the diversion report for the month of April 2011, using SD of greater than 2, it was noted that the name of RN 16 appeared on the report with the SD of 2.9 and 30 doses of injectable hydromorphone (generic name for Dilaudid).</p> <p>The April diversion report using the SD of greater than 2 and greater than 3 were compared and it was noted that in ED alone the number of users that appeared on the report increased from 7 users (for SD greater than 3) to 18 users (for SD greater than 2).</p> <p>During an interview on July 27, 2011, at 3:30 p.m., the DP acknowledged that the earlier</p>	A 494		

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

PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2011
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A 494	<p>Continued From page 94</p> <p>detection of the drug diversion by RN 16 could have been possible had the facility used the SD greater than 2 rather than 3 and that additional investigation would be needed.</p> <p>Review of the facility's policy and procedure titled, "Controlled Substances" revealed the following:</p> <p>"Policy:</p> <p>A. General ...</p> <p>3. There will be a perpetual accountability of all controlled substances including waste, discrepancies, and inventories through review of Pyxis generated reports.</p> <p>Procedure ...</p> <p>F. Miscellaneous Information ...</p> <p>2. The pharmacy monitors the use of the MedStation system by running daily reports. The reports are reviewed for any discrepancies, wrong patients entered into the system, and any other potential abuses to circumvent the system from its original intent i.e., entering fictitious patient numbers or names to gain access to the system.</p> <p>3. Pharmacy Managers will distribute "diversion" reports to nursing managers at least every 2 months that show the frequency of access of caregivers to controlled substances in relation to unit averages. Those individuals with the highest rates of access on the reports should be evaluated (i.e. random chart reviews) to assess diversion issues by the Nurse managers ..."</p> <p>During the same interview, the DP was asked if controlled substances wastage report was generated and reviewed by the Pharmacy. The DP stated that other than the monthly diversion</p>	A 494		

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

PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2011
NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM			STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562	
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A 494	Continued From page 95 report there were no other pharmacy generated reports that were reviewed. On July 28, 2011, at 11:30 a.m., during an interview, Pharmacist 2 stated that only the charge nurses would be able to enter patients into the Pyxis MedStation and the Pharmacy did not monitor and review the list of patients that were manually entered in to the Pyxis MedStation. Review of the document called, "Entered ADT (admit, discharge, transfer) Information" revealed that all RNs, staff and charge nurses could enter patients manually in order to access any medications available in the Pyxis MedStation. Review of the monthly diversion reports from July 2010, to present, indicated that the facility failed to consistently review the reports monthly, as some of the monthly reports were either not completed or incomplete. On August 2, 2011, at 2 p.m., during an interview, the DP acknowledged that monthly reviews of the diversion reports were not done consistently. The facility's failure to monitor controlled substances in the ED in accordance with the facility's policy and procedure resulted in the delay of drug diversion detection.	A 494		
A 500	482.25(b) DELIVERY OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law.	A 500	482.25(b) DELIVERY OF DRUGS	

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

PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391

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A 500	<p>Continued From page 96</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that drugs were controlled and distributed in accordance with the facility's policy and procedure and acceptable standards of practice by failing to:</p> <ol style="list-style-type: none"> 1. a. Conduct monthly audit of Drug Diversion Report in accordance with the facility's policy and procedure. b. Conduct monthly audit of Drug Diversion Report using Standard Deviation (SD) greater than two instead of three in accordance with the facility's policy and procedure; c. Conduct review of controlled substance wastage in accordance with the facility's policy and procedure; and, d. Conduct review of manual entry of ED patients for potentially inappropriate access to controlled substances by caregivers in accordance with the facility's policy and procedure. <ol style="list-style-type: none"> 2. Address potential delay in timely administration of medications caused by missing documentation of communication within pharmacy and other departments. 3. Have enough sterile water to mix the 36 vials of dantrolene 20 mg during emergency. 4. Update the facility's policy and procedure that reflected the content of the Adult Crash Cart. 5. Conduct the annual review of the hospital formulary in accordance with the facility's policy and procedure. 6. Ensure the Protonix (medication for the 	A 500		

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

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A 500	<p>Continued From page 97</p> <p>stomach) was substituted with the equivalent medication, according to the facility policy. The failed practice had the potential to result in medication administration error.</p> <p>7. Clarify the physician's "Medication Reconciliation Admission Orders, Inpatient" written on July 25, 2011, at :9:40 a.m., when "UR (unable to recall)" was written for dose, until July 26, 2011, for one of 73 patients (Patient 53). This failed practice had the potential to delay treatment to the patient as ordered by the physician.</p> <p>Findings:</p> <p>1. During an interview on July 27, 2011, at 4 p.m., Nurse Manager (NM) 6 stated that there were two incidences of controlled substance drug diversion that were identified and investigated that involved two RNs (RN 15 and RN 16) that worked in the Emergency Department (ED).</p> <p>The NM 6 stated that it was reported by a patient (Patient 74) that was admitted to an inpatient unit through the ED that the pain medications the patient received while in ED administered by RN 15 were not as effective as the pain medications received while in the inpatient nursing unit. This prompted an investigation that led to the identification of RN 15 diverting controlled substances.</p> <p>According to the electronic mail (e-mail) sent to several of the facility's leadership members dated July 14, 2011, by the NM 6,</p> <p>"I received a patient complaint regarding (RN 15)'s care. The patient (Patient 74) stated that</p>	A 500	<p>Continued From page 96</p> <p>Finding 1:</p> <p>Actions Taken:</p> <p>1. The CNO met with the Pharmacy Director to discuss the survey findings. The Pharmacy Director will be required to submit monthly reports to the CNO regarding compliance with the Hospital's policies regarding controlled substances.</p> <p>2. The Pharmacy Director reviewed all existing policies and procedures relating to maintaining and implementing the pharmacy's system for readily identifying drug diversion of controlled substances. The Pharmacy Director inserviced pharmacy managers on the policies related to monitoring for drug diversion of controlled substances, including investigating reports of potential drug diversion, monitoring the automated drug dispensing system for discrepancies and inappropriate manual overrides, and generating accurate and complete monthly diversion reports. Pharmacy Managers will complete reviews of controlled substance access at least weekly, to proactively discover any diversion possibilities. Reviews may include Override report, Discrepancy report, Return and Waste report,</p>	7/27/11	9/6/11

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

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A 500	<p>Continued From page 99</p> <p>mg doses and one 0.5 mg dose from 2 mg injectable Dilaudid without documented wastage.</p> <p>During an interview on July 27, 2011, at 1:40 p.m., the DP stated that the she was informed of the two drug diversion cases by NM 6 who requested the ED narcotic activity report from the Pharmacy. The DP stated that she provided NM 6 the reports printed from the Pyxis Reporter that listed high users of controlled substances with the patients' names, and from CareFusion (Pyxis analytics software that provides statistics and analysis).</p> <p>The DP stated the investigation was conducted by NM 6 and there was no further investigation done by the Pharmacy. When asked about the narrow time frame of narcotic activity by the two RNs reviewed by NM 6, the DP acknowledged that the investigation could have been more thorough.</p> <p>Review of the facility's policy and procedure titled, "Automated Drug Dispensing Systems" revealed the following:</p> <p>"K. Reports.</p> <ol style="list-style-type: none"> 1. Open Discrepancies: Will be used to ensure that all discrepancies are resolved in a timely manner ... 2. Discrepancy Report: Will be used by the unit charge nurses to verify with the following shift unit charge nurse that there are no unresolved discrepancies ... 4. Profile Override: Will be used to verify that all medications that were obtained from the Pyxis Medstation (Automated Drug dispensing Cabinet: ADC) via "override" have an order written and 	A 500	<p>Continued From page 99</p> <p>The CNO shall report on compliance monthly to the hospital Patient Safety Council, who will report through the hospital Quality Oversight Structure to the Board of Governors monthly.</p> <p>Persons Responsible:</p> <p>Pharmacy Director CNO</p>		

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

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A 500	<p>Continued From page 100</p> <p>entered into the pharmacy computer system.</p> <p>5. Diversion Reports:</p> <p>a. Will be generated monthly by the Pharmacy Managers documenting employees that show two or more standard deviations over the average removal rate of controlled substances for a particular nursing unit.</p> <p>b. The report will be distributed to the Nurse Managers for review, investigation and follow up.</p> <p>c. The Nursing Manager will state whether there is further study indicated or no further analysis is required and all data checks out and return the report to the Director of Pharmacy."</p> <p>During the same interview, the DP acknowledged that she did not know that the monthly diversion reports had to be generated using the standard deviation (SD) of greater than 2 rather than 3. Standard Deviation (SD) - is a measurement calculation used to show how much variation there is from the average amount. Using the standard deviation number of 3, instead of the number required in the facility policy which is 2, caused the facility to miss the deviations that would've been on the report had they followed their policy.</p> <p>During an interview on July 27, 2011, at 2 p.m., Pharmacist 1 stated that the monthly diversion reports were run using SD greater than 3 since July 2010, and the SD greater than 3 had been used because it was the system default and admitted he was not able to change the parameters.</p> <p>When Pharmacist 1 was able to run the diversion report for the month of April 2011, using SD of greater than 2, it was noted that the name of RN</p>	A 500			

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

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A 500	<p>Continued From page 101</p> <p>16 appeared on the report with the SD of 2.9 and 30 doses of injectable hydromorphone (generic name for Dilaudid).</p> <p>The April diversion report using the SD of greater than 2 and greater than 3 were compared and it was noted that in the ED alone the number of users that appeared on the report increased from 7 users (for SD greater than 3) to 18 users (for SD greater than 2).</p> <p>During an interview on July 27, 2011, at 3:30 p.m., the DP acknowledged that the earlier detection of the drug diversion by RN 16 could have been possible had the facility used the SD greater than 2 rather than 3 and that additional investigation would be needed.</p> <p>Review of the facility's policy and procedure titled, "Controlled Substances" revealed the following:</p> <p>"Policy:</p> <p>A. General ...</p> <p>3. There will be a perpetual accountability of all controlled substances including waste, discrepancies, and inventories through review of Pyxis generated reports.</p> <p>Procedure ...</p> <p>F. Miscellaneous Information ...</p> <p>2. The pharmacy monitors the use of the MedStation system by running daily reports. The reports are reviewed for any discrepancies, wrong patients entered into the system, and any other potential abuses to circumvent the system from its original intent i.e., entering fictitious patient numbers or names to gain access to the system.</p>	A 500			

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

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A 500	<p>Continued From page 102</p> <p>3. Pharmacy Managers will distribute "diversion" reports to nursing managers at least every 2 months that show the frequency of access of caregivers to controlled substances in relation to unit averages. Those individuals with the highest rates of access on the reports should be evaluated (i.e. random chart reviews) to assess diversion issues by the Nurse managers ..."</p> <p>During the same interview, the DP was asked if controlled substances wastage report was generated and reviewed by the Pharmacy. The DP stated that other than the monthly diversion report, no other pharmacy generated reports were reviewed.</p> <p>On July 28, 2011, at 11:30 a.m., during an interview, Pharmacist 2 stated that only the charge nurses would be able to enter patients into the Pyxis MedStation and the Pharmacy did not monitor and review the list of patients that were manually entered into the Pyxis MedStation.</p> <p>Review of the document called, "Entered ADT (admit, discharge, transfer) Information" revealed that all RNs, staff and charge nurses could enter patients manually in order to access any medications available in the Pyxis MedStation.</p> <p>Review of the monthly diversion reports indicated that they were not consistently reviewed monthly as some of the monthly reports were either not completed or incomplete.</p> <p>On August 2, 2011, at 2 p.m., during an interview, the DP acknowledged that monthly reviews of the diversion reports were not done consistently.</p>	A 500		

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

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A 500	Continued From page 104 Pharmacist 5 was not sure what "UR" meant and could not tell if any of the pharmacists made any attempt to communicate the need for the missing information for Pharmacy order processing to the nurse who received the telephone order from the physician or the ordering physician. Pharmacist 5 stated that there was no documentation as to which pharmacist contacted whom and when. Pharmacist 5 also was not sure who should have been responsible for follow-up and how often. Review of the preprinted form indicated "UR" stood for "unable to recall." During concurrent interview, the DP acknowledged that without initial documentation and follow-up by the pharmacy the patient might not be able to get needed medication timely. The Pharmacy computer screen that showed "on hold" physician orders were reviewed with Pharmacist 5 on July 26, 2011, at 11:45 a.m., in the Pharmacy at the Inland Valley Campus. It was observed that five out of seven orders that were assigned "on hold" status were incomplete orders that were written on the preprinted form titled, "Medication Reconciliation Admission Orders, Inpatient." The medications listed on this form were taken by the patient at home before being admitted to the facility. The review of the preprinted order forms indicated staff nurses were gathering medication information, filling out the preprinted form with home medications, and receiving telephone physician orders for medications taken by the patient at home. The preprinted forms would	A 500	Continued From page 104. discussed the issue of physicians signing the medication reconciliation forms when there are incomplete medication lists from patients (e.g., unable to recall dose). The CMO issued a letter to the physicians advising them that it is expected that they will review the medication reconciliation form in its entirety prior to checking the "yes" box on the form to order the medication. This will decrease the number of medications that need to be clarified and ensure the timely delivery of medications to patients. The PI Director or qualified designee shall provide the CMO with a list monthly of physicians signing off on incomplete medication reconciliation forms and the CMO and/or Chief of Staff will take 1:1 action with the individual physician. Compliance and Monitoring: The Pharmacy Director or qualified designee shall perform daily reviews of "on hold" medications pending physician clarification for three months (and then re-evaluate) to monitor compliance. Corrective action shall be taken if needed. The CNO shall report on compliance monthly to the hospital Patient Safety Council, who will report through the hospital Quality Oversight Structure to the Board of Governors monthly. Persons Responsible: Pharmacy Director CNO	9/6/11 and ongoing

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

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A 500	<p>Continued From page 105</p> <p>become physician orders for pharmacy processing and dispensing. Each of the five "on hold" preprinted orders reviewed had incomplete information that required clarification by the ordering physicians, such as no strength or frequency for medications that were ordered to continue by the ordering physicians as indicated by the check in the "yes" to continue box.</p> <p>One of the orders was written on July 24, 2011, two days prior, for gabapentin (medication used for seizure and nerve pain) "unsure dose" by mouth once a day for stomach pain.</p> <p>During the same interview, the DP also confirmed that the completed forms were actual orders that the Pharmacy could process. The DP stated the listed medications on the forms could be continued at the hospital or the physician could choose to not continue while patients were in the facility. The DP also stated that this process of completing the form meant the Pharmacy was an active part of ensuring that important home medications were continued during the patient stay at the facility.</p> <p>The DP acknowledged that the system was not perfect as of now and the facility was in the initial stages during which time date(data) would be collected.</p> <p>According to the facility's policy and procedure titled, "Medication Reconciliation Across the Continuum of Care,"</p> <p>"Procedure: 1. At admission to all units of SWHCS a licensed caregiver will obtain from the patient or caregiver</p>	A 500		

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

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OMB NO. 0938-0391

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A 500	<p>Continued From page 106</p> <p>the current medications used at home, including OTC and herbal products within 8 hours of admission ...</p> <p>d) This information will be recorded on the Medication Reconciliation form ...</p> <p>2. For Inpatients, the admitting a physician will consider whether to continue or discontinue the medications on admission ...</p> <p>b) The completed form is now a physician's admitting order and will be faxed to the pharmacy and placed in the medical record in front of the physician's orders.</p> <p>i. The medication reconciliation form will remain the chart throughout the patient's stay."</p> <p>3. During inspection of the Malignant Hyperthermia (MH) Cart located in PACU (Post Anesthesia Care Unit) on July 25, 2011, at 3:30 p.m., it was noted that the MH Cart contained two 1000-ml injectable bags of sterile water.</p> <p>MH crisis is a biochemical chain reaction response, "triggered" by commonly used general anesthetics and the paralyzing agent succinylcholine, within the skeletal muscles of susceptible individuals. The general signs of the MH crisis include tachycardia, a greatly increased body metabolism, muscle rigidity and/or fever that may exceed 110 degrees F. Severe complications include: cardiac arrest, brain damage, internal bleeding or failure of other body systems. Thus, death, primarily due to a secondary cardiovascular collapse, can result.</p> <p>Review of the content list for the MH Cart indicated there should be 2, 1000-ml bags of sterile water.</p>	A 500	<p>Continued From page 105</p> <p>Findings 3 and 4:</p> <p>1. The Pharmacy Director reviewed and revised the content list for the Malignant Hyperthermia (MH) Cart to include two 2000 ml injectable bags of sterile water for the preparation of 36 vials of Dantrolene. Each MH Cart now contains two 2000 ml injectable bags of sterile water.</p> <p>2. The Pharmacy Director reviewed the "Emergency/Urgent/Specialty Drug Supplies – Kits" policy to ensure the "Code Cart; Adult Medication Tray" included Atropine 0.4 mg/ml in the Adult Crash Carts.. The "Code Cart; Adult Medication Tray" list was updated to include 4 vials of Atropine 0.4 mg/ml.</p> <p>3. Pharmacy and nursing staff were inserviced on revisions to the MH Cart and Adult Crash Carts.</p> <p>4. The Pharmacy Director and P & T Committee shall review crash cart and MH lists at least annually to ensure sufficient supplies in carts.</p>	7/27/11 7/27/11 9/6/11 9/6/11	

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

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A 500	<p>Continued From page 107</p> <p>Review of the facility's policy and procedure titled, "Emergency/Urgent/Specialty Drug Supplies-Kits" was reviewed and it indicated one 2000-ml injectable bag of sterile water in the MH Cart.</p> <p>The MH Cart contained 36 vials of Dantrolene (drug used to treat malignant hyperthermia) 20 mg that would need 60 ml of sterile water to mix the powder in each of the 36 vials should there be a need. This would require a total of 2160 ml of sterile water and the facility's MH Cart contained only 2000 ml of sterile water.</p> <p>During a concurrent interview the DP acknowledged that the MH Cart did not have enough sterile water to mix all 36 vials of Dantrolene 20 mg.</p> <p>4. During tour of Medical/Surgical/Telemetry Unit One West on July 25, 2011, at 9:20 a.m., it was observed that the facility's Adult Crash Cart contained 4 vials of a medication called Atropine (ET tube) 0.4 mg/ml that was not listed as one of the medications approved to be included in the Cart.</p> <p>Review of the facility's policy and procedure titled, "Emergency/Urgent/Specialty Drug Supplies-Kits" indicated that Atropine (ET tube) 0.4 mg/ml was not included in the Adult Crash Cart content list.</p> <p>During concurrent interview, the DP agreed that the facility's policy and procedure did not include the drug and stated the policy and procedure needed to be updated.</p> <p>5. The facility's Pharmacy and Therapeutics Committee Meeting Minutes from January 2010,</p>	A 500	<p>Continued From page 107</p> <p>Compliance and Monitoring:</p> <p>The Director of Pharmacy or designated Pharmacist shall check MH Carts at least every 30 days and complete the MH Checklist. The Director of Pharmacy or designated Pharmacist shall check Adult Crash Carts at least every 30 days to ensure medications in compliance with supply list. Corrective action shall be taken if needed. The Pharmacy Director shall report on compliance monthly to the hospital PI Council, who will report through the hospital Quality Oversight Structure to the Board of Governors monthly.</p> <p>Person Responsible: Pharmacy Director</p> <p>Finding 5: Actions Taken:</p>	9/6/11 and ongoing	

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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM			STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562	
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A 500	<p>Continued From page 108 to June 2011, were reviewed and it was noted that the minutes did not indicate the annual review of the hospital's drug formulary was discussed during the meetings.</p> <p>During an interview on July 28, 2011, at 12 p.m., the DP acknowledged that the meeting minutes did not indicate the discussion of the annual review of the formulary and was not able to recall the last time the formulary was reviewed.</p> <p>Review of the facility's policy and procedure titled, "Medication: Formulary" indicated, "To maintain a viable formulary, the Pharmacy and Therapeutics Committee will annually review classes of drugs based on emerging safety and efficacy data in the clinical literature ..."</p> <p>6. On July 25, 2011, Patient 29's record was reviewed. The patient was admitted to the Medical-Surgical unit on [REDACTED] 2011, with orders that included, "Protonix 40 mg po BID."</p> <p>The "Physician's Order Sheet" dated July 25, 2011, at 7:50 a.m., indicated, "(in printed form) Prilosec 40 mg po daily is auto subs for Protonix 40 mg po daily."</p> <p>On July 25, 2011, at 3:25 p.m., Patient 29's record was reviewed with Pharmacist 3. The Pharmacist stated the pharmacy department automatically substituted Protonix to Prilosec. He stated he was the pharmacist that processed the "autosub" order. He stated he typed in the order and stamped it in the "Physician's Order Sheet." He stated the frequency of the Prilosec should be equivalent with the Protonix order, twice a day, not once a day.</p>	A 500	<p>Continued From page 108</p> <p>1. The P & T Committee performed an annual review of the medication formulary by class and usage on 8/23/11 and documented it in the meeting minutes in accordance with hospital policy. The review is a standing agenda item for the P & T Committee on an annual basis The Pharmacy Director reviewed the Medication: Formulary policy with the P & T Committee.</p> <p>Compliance and Monitoring: The Director of Pharmacy shall provide evidence of the annual medication formulary review to the CNO on an annual basis to ensure compliance. The Pharmacy Director shall report on compliance annually to the hospital PI Council, who will report through the hospital Quality Oversight Structure to the Board of Governors. Person Responsible: Pharmacy Director</p> <p>Finding 6:</p> <p>Actions Taken:</p> <p>1. The Director of Pharmacy inserviced the Pharmacists (including the applicable p Pharmacist) on the "Automatic Therapeutic Substitution" policy, which provides for substitution of a clinically equivalent dose regimen as the original order and same route of administration.</p> <p>2. The MAR was corrected.</p> <p>Compliance and Monitoring: The Director of Pharmacy or qualified designee shall review 70 charts monthly for 3 months (and then re-evaluate) to achieve a goal of 100% compliance with automatic substitutions. Corrective action shall be taken if necessary. The Director of Pharmacy shall</p>	<p>8/23/11</p> <p>9/6/11 and ongoing</p> <p>8/30/11</p> <p>8/30/11</p> <p>9/6/11 and ongoing</p>

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

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A 500	<p>Continued From page 110</p> <p>p.m. The medication "Robitussin DM" indicated two tablespoons for the dose and the medication "Pepcid" indicated 20 milligrams for the dose. The order was a telephone order taken by RN 3 on July 25, 2011, at 5 p.m., from the physician.</p> <p>The "Medication Administration Record (MAR)" dated July 25, 2011, did not indicate Robitussin DM, Claritin, and Pepcid were available for administration to Patient 53.</p> <p>The "MAR" dated July 26, 2011, indicated the orders for Robitussin DM, Claritin, and Pepcid but they were hand written on the "MAR" versus generated from the computer software system.</p> <p>On July 26, 2011, at 1:10 p.m., an interview was conducted with RN 3. She stated she "scanned" the orders to the pharmacy on July 25, 2011, at 5 p.m., but she did not clarify the orders with the physician until July 26, 2011, sometime in the morning, even though the "revised" "Medication Reconciliation Admission Orders, Inpatient" indicated she had taken a telephone order from the physician on July 25, 2011, at 5 p.m., clarifying the "Dose" orders for both "Robitussin DM" and "Pepsid." In addition, RN 3 stated she should have clarified the dose orders for both "Robitussin DM" and "Pepsid" with the physician on July 25, 2011, before she noted the order, and she should have dated the "revised" "Medication Reconciliation Admission Orders, Inpatient" with the date she actually wrote the order which was July 26, 2011, or wrote the order as a "late entry."</p> <p>The facility policy and procedure titled "Physician's Orders" reviewed December 2010,</p>	A 500	<p>Continued From page 110</p> <p>the order prior to the physician checking the "yes" box on a medication reconciliation form that has incomplete information (e.g., unable to recall dose or frequency).</p> <p>3. The Pharmacy Director and CMO discussed the issue of physicians signing the medication reconciliation forms when there are incomplete medication lists from patients (e.g., unable to recall dose). The CMO issued a letter to the physicians advising them that it is expected that they will review the medication reconciliation form in its entirety prior to checking the "yes" box on the form to order the medication. This will decrease the number of medications that need to be clarified and ensure the delivery of medications to patients. The PI Director or qualified designee shall provide the CMO with a list monthly of physician signing off on incomplete medication reconciliation forms and the CMO and/or Chief of Staff will take 1:1 action with the individual physician.</p> <p>Compliance and Monitoring:</p> <p>The Pharmacy Director or designee shall perform daily reviews of "on hold" medications pending physician clarification for three months (and then re-evaluate) to monitor compliance. Corrective action shall be taken if needed. The CNO shall report on compliance monthly to the hospital Patient Safety Council, who will report through the hospital Quality Oversight Structure to the Board of Governors monthly.</p> <p>Persons Responsible:</p> <p>Pharmacy Director CNO</p>	9/6/11	9/6/11 and ongoing

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

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A 500	Continued From page 111 indicated "To establish guidelines for obtaining and processing physician's orders to ensure prompt quality patient care is provided. ... Physician's orders will be accurately processed and promptly followed. ... Written orders will be transcribed and implemented promptly. ... If the order is not complete, the ordering physician will be called to clarify the order. ..."	A 500			
A 505	The facility policy and procedure titled "Medication Reconciliation Across the Continuum of Care" issued 2008, revised April 2011, indicated "... Clarifications of missing or erroneous information will be written on the physician's order sheet, not the medication reconciliation sheet. The pharmacist will contact the physician regarding further clarification if needed. ..." 482.25(b)(3) UNUSABLE DRUGS NOT USED Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure an unusable medication was not available for patient use. Findings: During an inspection of the Pharmacy located on the Rancho Springs Campus on July 25, 2011, at 10:45 a.m., it was noted in the Pharmacy's medication refrigerator there was an open injectable vial of potassium phosphate (electrolyte supplement) SDV (single dose vial) 50 ml with the open date of July 16, 2011.	A 505	482.25(b)(3) UNUSABLE DRUGS NOT USED Action Taken 1. The Director of Pharmacy reviewed the "Drug admixture/Sterile Parenteral Solutions Guidelines" policy, which provides that single use sterile drugs and devices shall not be reused. All pharmacy staff were inserviced on this policy, emphasizing that all single dose vials must be discarded immediately after use and are not to be kept in the pharmacy after initial use. Failure to comply will result in progressive corrective action. 2. The bottle of potassium phosphate was discarded and a review of the pharmacy was performed to check for any other open single dose vials. None were found. 3. The Pharmacists will review the pharmacy prep areas and pharmacy medication refrigerator throughout the shift to ensure that single dose vials are discarded.	8/30/11 7/25/11 7/26/11	

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

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A 505	Continued From page 112	A 505	Continued From page 112 Compliance and Monitoring: The Director of Pharmacy and/or CNO shall perform random inspections of the pharmacy at least bi-weekly for 3 months (and then re-evaluate) to achieve a goal of 100% compliance with disposing of single dose vials after initial use. Corrective action shall be taken immediately. The Director of Pharmacy shall report on compliance bimonthly to the P&T Committee, who will report through the hospital Quality Oversight Structure to the Board of Governors monthly.	8/30/11 and ongoing
A 536	During a concurrent interview, the DP agreed that SDV vials should have been discarded immediately after use and should not have been kept in the medication refrigerator. The facility's policy and procedure titled, "Drug admixture/Sterile Parenteral Solutions Guidelines" was reviewed and it stated, "...Single-use sterile drugs and devices shall not be reused. Unused portions of single-use sterile drugs shall not be saved for later use ..." 482.26(b)(1) SAFETY FOR PATIENTS AND PERSONNEL Proper safety precautions must be maintained against radiation hazards. This includes adequate shielding for patients, personnel, and facilities, as well as appropriate storage, use and disposal of radioactive materials. This STANDARD is not met as evidenced by: Based on interview and record review, the facility: 1. Failed to ensure an employee in the surgery department had a radiation monitoring device; and 2. Failed to retrieve an employee's radiation monitoring device when it was not turned into the Nuclear Medicine Technologist at the end of the first quarter for 2011. These failed practices had the potential to prevent the employee and the facility from knowing the radiation hazards facility personnel were exposed to.	A 536	Person Responsible: Pharmacy Director 482.26(b)(1) SAFETY FOR PATIENTS AND PERSONNEL Actions Taken: 1. The policy for "Radiation Safety and Permissible Doses: Occupational" was reviewed and revised to include radiation sensitive areas that require staff to maintain a safety badge. The MEC and Board of Governors approved the policy. The policy and procedure has been reviewed at the Imaging Department meeting. All applicable staff were inserviced on the revised policy. 2. The Manager of the area is responsible for notifying the Radiation Safety Officer/designee of all newly hired staff. Newly hired staff members are assigned a radiation monitoring badge and are educated to their responsibility for the badge. In radiation sensitive areas, the Manager or designee shall assist the Radiation Safety Officer to ensure a smooth process for badge acquisition and the quarterly exchange. 3. Radiation monitoring badges were provided to staff in radiation sensitive areas. A radiation monitoring badge was provided to RN 8. OR Tech 1 was assigned a new badge.	8/5/11 7/28/11 7/28/11

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 536	<p>Continued From page 113</p> <p>Findings:</p> <p>1. On July 25, 2011, at 2:50 p.m., a tour of perioperative services was conducted.</p> <p>On July 25, 2011, at 3:45 p.m., an interview was conducted with RN 8, who was assigned to circulate in the operating rooms. When RN 8 was asked about the location of her radiation monitoring device, RN 8 stated she did not have a radiation monitoring device and had never been issued a radiation monitoring device. In addition, RN 8 stated her employment at the facility started on June 6, 2011, and she was a full time employee.</p> <p>On July 25, 2011, at 3:55 p.m., an interview was conducted with Nurse Manager (NM) 1. She stated the completion of the form for RN 8 to obtain a radiation monitoring device had not been done or submitted to the nuclear medicine technologist.</p> <p>On July 26, 2011, at 9:20 a.m., an interview was conducted with Manager 1 and Nuclear Medicine Technologist (NMT) 1. They stated each employee who worked in surgery should have a radiation monitoring device. NMT 1 stated a radiation monitoring device was never requested for RN 8 and a radiation monitoring device had never been issued to RN 8.</p> <p>2. On July 26, 2011, at 9:20 a.m., an interview was conducted with Manager 1 and Nuclear Medicine Technologist (NMT) 1. They stated a list of employees who had been assigned a radiation monitoring device was maintained, and on the first day of a new quarter all badges were turned</p>	A 536	<p>Continued From page 113</p> <p>4. The Manager of each radiation sensitive area completed a staff roster review and provided the information to the Director of Imaging.</p> <p>5. Quarterly, when badges are exchanged, the Radiation Safety Officer/designee will contact the Managers and review their list of employees assigned radiation badges. In the event a badge is lost or missing, a new badge will be assigned.</p> <p>Compliance and Monitoring:</p> <p>The Radiation Safety Officer or designee shall perform random rounds weekly for 3 months (and then re-evaluate) to achieve a goal of 100% compliance with radiation monitoring devices. Corrective action shall be taken as necessary during rounds. Compliance is reported quarterly to the Radiation Safety Committee and monthly to the Board of Governors.</p> <p>Person Responsible:</p> <p>Radiation Safety Officer</p>	<p>9/1/11</p> <p>8/5/11</p> <p>9/6/11 and ongoing</p>

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A 536	<p>Continued From page 114</p> <p>into NMT 1 and a new radiation monitoring device was issued to the employee. In addition, they stated the "new" radiation monitoring device was given to the employee before the "old" radiation monitoring device was turned into NMT 1.</p> <p>On July 26, 2011, at 9:30 a.m., the "Radiation Dosimetry Report" for the monitoring period of January 15, 2011, through April 14, 2011, was reviewed with Manager 1 and NMT 1. The "Radiation Dosimetry Report" indicated the radiation monitoring device for OR/Surgical Technologist 1 was "absent." NMT 1 stated the designation of "absent" on the report indicated the radiation monitoring device had never been given to her at the end of the quarter.</p> <p>On July 26, 2011, at 9:45 a.m., an interview was conducted with NM 5. She stated surgery employees should wear their radiation monitoring devices when radiation was involved in the surgical case. NM 5 stated she had never been informed that a radiation monitoring device from a surgery employee had not been turned into NMT 1 at the end of a quarter. In addition, NM 5 stated she was never informed OR/Surgical Technologist 1 had not given her radiation monitoring device to NMT 1 at the end of the first quarter for 2011.</p> <p>On July 27, 2011, at 2:50 p.m., an interview was conducted with NMT 1 and Director Imaging Services (DIS). They stated there were no systems currently in place to notify the employee or the employee's manager/director of an "absent" badge. In addition, they stated the manager/director for any employee hired by surgery or specials (interventional radiology) were</p>	A 536		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 536	Continued From page 115 to inform NMT 1 that a radiation monitoring device was required for that employee. The facility policy and procedure titled "Radiation Monitoring Devices: Personnel (Film Badges)" revised April 2011, indicated "To insure appropriate staff have radiation monitoring devices. The Imaging Department will provide radiation monitoring film badges at no charge to those employees who are subject to possible occupational exposure to radiation. ... The nuclear medicine technologist is responsible for the issuance of film badges, and for maintaining the appropriate records. ..."	A 536		
A 631	482.28(b)(3) THERAPEUTIC DIET MANUAL A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and food service personnel. This STANDARD is not met as evidenced by: Based on staff interviews and record review, the hospital failed to have a therapeutic diet manual that was specific to the diets that the hospital routinely ordered, and provided guidance to the medical, nursing and food service staff for the ordering and preparation of patient. This failed practice had the potential to result in inaccurate diets being served to patients in a hospital system with a licensed bed capacity for 252 patients. Findings: During an interview with the Director of Nutritional Services (DNS), on July 26, 2011, at 12:45 p.m., she stated the hospital used the American Dietetic Association (ADA) online Nutrition Care	A 631	482.28(b)(3) THERAPEUTIC DIET MANUAL Actions Taken: 1. The Director of Nutritional Services created an addendum to the Nutrition Care Manual outlining specific therapeutic diets and "sample" menus of these diets that are served at SWHCS. In this addendum all the diets that are currently provided at SWHCS are now available to be viewed by all staff on the SWHCS intranet. 2. The addendum was approved by the P&T committee. 3. The addendum was approved at the MEC and Broad of Governors. 4. The addendum is accessible by all staff on the SWHCS Intranet. 5. Nursing Leadership, nursing staff and physicians were notified of the addendum via written communication. 6. Four printed copies of the addendum have been placed inside the existing Nutrition Care Manual (NCM) binders in the house supervisor's offices as well as the diet offices at each respective campus.	8/2/11 8/10/11 8/26/11 8/29/11 8/29/11 8/30/11

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A 631	<p>Continued From page 116</p> <p>Manual (NCM) as their diet manual. She stated that the NCM provided nutrition information regarding many different diets for many different specific diagnoses, whether or not the hospital used those diets for their patients.</p> <p>The DNS further stated that although the NCM provided information about some of the diets the hospital routinely provided, it didn't define many of the typical diets the hospital uses, such as: Soft diets, 2000 ADA diets, the American Heart Association (AHA) diet, the facility's specific Gastric Bypass clear liquid diet and how the hospital specifically defines their Renal diet (in terms of amount of protein, grams of sodium, potassium and phosphorus) when the physician orders it without those parameters defined. The DNS was unable to state how the NCM could be consistently used as guidance for ordering and preparing patient diets.</p> <p>A concurrent review of the ADA NCM on the hospital's computer system with the DNS revealed that these above diets were not present or were not specifically defined as being consistent with what the hospital provided on these diets.</p> <p>A review of the hospital's policy titled, "Diet Manual" (dated November, 2010) revealed that the purpose of the diet manual was to provide criteria to standardize nutritional care throughout the hospital. It further states that the (diet manual) served as a guide to ordering diets, and that served menus would be consistent with the requirements in the manual.</p>	A 631	<p>Continued From page 116</p> <p>Compliance and Monitoring:</p> <p>1. At least annually and before a new diet is added to the hospital's menu, the Director of Nutritional Services will review the NCM and the information provided in the addendum to the NCM to ensure all diets provided are defined and that the information is readily available to all medical, nursing, and food service personnel.</p> <p>2. The Pharmacy and Therapeutics Committee approve the diet manual and its addendum at least annually and will report through the hospital Quality Oversight Structure for approval by MEC and the Board of Governors.</p> <p>Persons Responsible:</p> <p>Director of Nutritional Services COO</p>	9/6/11 and ongoing	
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE	A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE		

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A 724	<p>Continued From page 117</p> <p>Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the calibration of the Vaisala wall monitors (the device that is mounted on the wall for purpose of measuring the temperature and humidity of the room) in the surgery areas in Inland medical Center and in the Women's Center at Rancho Springs Hospital were being completed as recommended by the manufacturer.</p> <p>In addition, facility failed to ensure the Vaisala equipment was maintained to ensure acceptable level of safety and quality, by not having a system in place to ensure the accuracy of the humidity readings in the surgery areas in Inland medical Center and in the Women's Center at Rancho Springs Hospital.</p> <p>These failed practices potentially placed the patients at risk for infections and of fire in an oxygen rich environment.</p> <p>Findings:</p> <p>A tour of the surgery department, including the Sterile Processing Department was done on July 25, 2011, starting at 1:30 p.m.</p> <p>A concurrent interview was conducted with the Surgery Manager and RN 13, on July 25, 2011, at 3 p.m. The Surgery Manager stated the temperature and humidity of the Vaisala wall</p>	A 724	<p>Continued From page 117</p> <p>Actions Taken:</p> <ol style="list-style-type: none"> 1. The Director of Plant Operations compared the Vaisala (electronic) wall monitor readings to a new handheld fluke. The wall monitor readings in the Inland Valley surgery areas and in the Rancho Springs Women's Center were within 1-1.5% of the reading obtained with the fluke. The humidity readings were consistent and within the appropriate range for operating rooms. 2. The Director of Plant Operations contacted an approved vendor to service and calibrate the wall monitors. The vendor first validated the current functioning of the Vaisala wall humidity monitors. It was determined that they were within 1% prior to calibration. The vendor completed the calibration and validation of all Vaisala wall monitors at Inland Valley surgery areas and at Rancho Springs Women's Center. 3. The Chief Operating Officer provided a copy of the vendor's certification to the survey team. 4. The Chief Operating Officer and the Director of Plant Operations revised the policy and procedure titles, "Temperature Humidity Monitoring: Perioperative Services, Women's Services and Cardiovascular Services" to include information regarding electronic temperature and humidity monitoring system. The policy states that electronic temperature and humidity gauges will be calibrated annually according to manufacturer 	<p>7/26/11</p> <p>7/27/11</p> <p>7/28/11</p> <p>7/28/11</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2011
NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM			STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562	
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A 724	<p>Continued From page 118</p> <p>monitor is monitored and noted in the morning at 6 a.m., and prior to each surgery. The Surgery Manager further stated she believed the Vaisala devices were calibrated on a regular basis. The temperature/humidity and calibration logs were requested for review.</p> <p>On July 26, 2011, at 10 a.m., the Accreditation Manager was notified the survey team had not received the calibration logs requested the day before, on July 25, 2011. The policy and procedure for monitoring temperature and humidity was requested along with the manufacturer's instructions for the Vaisala device.</p> <p>On July 26, 2011, at 3:30 p.m., the Accreditation Manager was notified the survey team had not received the calibration logs for the Vaisala devices.</p> <p>Review of the the Vaisala manufacturer's instructions was completed on July 26, 2011. The Vaisala manufacturer's instructions indicated under CALIBRATION, "It is recommended that the humidity calibration is performed at least once a year...Humidity calibration...we recommend recalibration at least once a year..."</p> <p>On July 26, 2011, at 3:45 p.m., during an interview with the Plant Operations Manager, he stated the facility had not calibrated any of the Vaisala devices in the facility. The Plant Operations Manager further stated he was not aware that the Vaisala equipment had to be calibrated. The Plant Operations Manager stated he thought the calibration was done at the factory and that the equipment did not require recalibration. The Plant Operations Manager</p>	A 724	<p>Continued From page 118</p> <p>specifications. The Board of Governors approved the policy.</p> <p>5. The Director of Plant Operations ensured that the electronic wall humidity monitors were added to the Four Rivers program, which is the facility's preventative maintenance tracking system. The wall monitors are scheduled for annual calibration.</p> <p>6. The Plant Operations Managers ensure that the electronic wall humidity monitors are checked monthly with the hand-held fluke to validate on a regular and ongoing basis (between vendor calibrations) that the readings are consistent and within the appropriate range for the area.</p> <p>Compliance and Monitoring:</p> <p>1. The Plant Operations Managers ensures monthly checks of the electronic humidity monitors are completed and incorporated in the monthly preventative maintenance (PM) report.</p> <p>2. The Director of Plant Operations monitors the preventative maintenance (PM) reports to ensure that scheduled PM's are completed, including monthly spot checks and the annual calibration of the electronic wall humidity monitors. This information is incorporated into the regular Plant Operations report provided to the Environment of Care Committee who will report through the hospital Quality Oversight Structure to the Board of Governors.</p> <p>Persons Responsible:</p> <p>Director of Plant Operations COO</p>	07/28/11 8/30/11 9/1/11 9/1/11

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

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A 724	<p>Continued From page 119</p> <p>stated he did not know that Vaisala equipment had to be re-calibrated, "until now, after fully reading the manufacturer's instructions." The Plant Operations Manager stated the Vaisala had been installed in the facility about eight to fifteen months ago. Documentation of date the Vaisalas were installed in the facility were requested.</p> <p>Document review was conducted on July 27, 2011. The calibration certificates for IVMC indicated the Vaisala had been calibrated at the factory, on July and August 2009, prior to be shipped to the facility. The Service Work Order for Rancho Springs Hospital indicated that the Vaisala had been installed at the Women's Center on September 22, 2009.</p> <p>In a interview with the Chief Operating Officer, on July 28, 2011, at 10 a.m., the Chief Operating Officer stated the Vaisala devices had not been calibrated since installed in the facility in 2009. The Chief Operating Officer stated the Vaisala devices at IVMC were connected to plant operations. Plant operations had the capability to monitor the temperature and humidity in the areas with the Vaisala wall-mounted devices, but plant operations was not currently monitoring the data. The Chief Operating Officer stated the facility reviewed the temperature and humidity logs, but did not have a system in place to compare and validate the data being written down by staff. The Chief Operating Officer Staff did not use the temperature and humidity data being recorded by plant operations or a hand held fluke to validate an accurate reading of the Vaisala wall-mounted devices.</p> <p>The Temperature and Humidity policy and</p>	A 724			

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

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A 724	Continued From page 120 procedures were reviewed on July 28, 2011: a) The policy and procedure titled, "Temperature/Humidity: Control of Hospital," was received at IVMC. The policy and procedure received at IVMC was incomplete. The policy addressed hand held flukes, but not the Vaisala wall-mounted devices being used in surgery and Sterile Processing Department. b) The policy and procedure titled, "Temperature Humidity Monitoring: Perioperative Services, Women's Services and Cardiovascular Services," was received at Rancho Springs Hospital. The policy and procedure reviewed at Rancho Springs Hospital were inaccurate. The policy and procedure indicated, "Hand held devices (flukes) will be changed annually per recommended manufacturer's guidelines by plant operations...Electronic temperature and humidity gauges are self calibrating..." The facility failed to ensure the calibration of the Vaisala wall monitors in the surgery areas in Inland medical Center and in the Women's Center at Rancho Springs Hospital were being completed as recommended by the manufacturer. The facility failed to ensure the Vaisala equipment was maintained to ensure acceptable level of safety and quality, by not having a system in place to ensure the accuracy of the humidity readings in the surgery areas in Inland medical Center and in the Women's Center at Rancho Springs Hospital.	A 724		
A 748	482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as	A 748	482.42(a) INFECTION CONTROL OFFICER(S)	

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

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A 748	<p>Continued From page 121 infection control officer or officers to develop and implement policies governing control of infections and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement a policy to screen physician's for hepatitis (communicable liver infection). This failed practice could potentially create an increased risk of the spread of infection to patients in the facility from unscreened physicians.</p> <p>Findings:</p> <p>During an interview with the Director of the Medical Staff on July 28, 2011, at 3:45 p.m., she stated that she did not believe there was a policy requiring hepatitis screening for physicians on the Medical Staff.</p> <p>During an interview with the Management Consultant on July 29, 2011, at 11:00 a.m., she stated that there was no hepatitis screening for physicians on the Medical Staff.</p> <p>During a review of the facility policy, "Pre-employment Screening and Immunizations" (issued December, 2010), and the Medical Staff Bylaws on July 29, 2011, there was no requirement for hepatitis screening for physician members of the Medical Staff.</p> <p>During a review of the Medical Staff files for physicians MS 2, MS 6, MS 7, MS 8, MS 9, MS 10, and MS 11 on July 28, 2011, the files did not contain evidence that the physicians receiving screening for communicable hepatitis. The</p>	A 748	<p>Continued From page 121</p> <p>Actions Taken:</p> <ol style="list-style-type: none"> 1. The Director of Infection Prevention met with Hospital and Medical Staff Leadership and the CMO regarding obtaining information on Hepatitis B vaccination from medical staff members (physicians and AHPs). 2. The CMO developed a Hepatitis B Vaccination Informational/Questionnaire survey as a screening tool for medical staff members. This screening tool shall be provided during the initial and reappointment process to the Medical Staff applicants and members. The hospital will offer education materials and vaccination to the medical staff members if requested. 3. The CMO sent the Hepatitis B Vaccination Informational/Questionnaire survey to all current members of the medical staff and are collecting responses. <p>Compliance and Monitoring:</p> <p>The Medical Staff Office will maintain a medical staff log monitoring participation in completing the Hepatitis B Vaccination Informational/Questionnaire survey and report to the CMO and the Director of Infection Prevention. The CMO shall report to the MEC, who will report through the hospital Quality Oversight Structure to the Board of Governors.</p>	<p>7/29/11</p> <p>9/6/11</p> <p>9/6/11</p> <p>9/6/11</p> <p>9/6/11</p>	

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A 748	Continued From page 122 physicians were not asked about a medical history of hepatitis or a history of hepatitis vaccination, and there were no laboratory results regarding hepatitis seen for those members of the Medical Staff. During a review of the Center for Disease Control "Guideline for infection control in health care personnel," 1998 "Hepatitis B vaccination of health care personnel who have contact with blood and body fluids can prevent transmission of HBV and is strongly recommended...The OSHA bloodborne pathogen standard mandates that hepatitis B vaccine be made available, at the employer's expense, to all health care personnel with occupational exposure to blood or other potentially infectious materials. ²⁷	A 748	Continued From page 122 Person Responsible: Director of Infection Prevention CMO	
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure; 1. The risk of infection was minimized for one of 73 sampled patients (Patient 1), when facility staff failed to assess the necessity for Patient 1's indwelling urinary catheter (a tube leading from the bladder to outside the body to drain urine). This failed practice could potentially result in the possibility of an unnecessary indwelling urinary catheter and the increased risk of infection; and	A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 749	Continued From page 123 2. The ice machine in the kitchen was maintained in a sanitary manner. These failed practices could potentially lead to an increased risk of infection for patients. Findings: 1. Review of the medical record of Patient 1 on July 26, 2011, indicated Patient 1 had a indwelling urinary catheter placed prior to surgery on [REDACTED] 2011. The medical record contained three stickers placed in the "Physician's Orders" section of the chart, for documentation of the medical necessity of central lines (tubes extending from a major blood vessel to outside the body) and indwelling urinary catheters. The pre-printed stickers contained check-boxes on which the existence of central lines or a indwelling urinary catheter were to be documented, and boxes to indicate the reason for the lines or catheter. The first such sticker in Patient 1's medical record was inserted on February 9, 2011, and has no boxes checked and was unsigned-the pre-printed sticker was left blank. The second sticker was placed on February 10, 2011, has the box "medical condition prohibits use of bedpan or bedside commode" checked, and the physician's signature, but no date or time signed. Review of the Patient Progress Notes on February 10, 2011, indicated Patient 1 ambulated in the hallway on that date. There was no documentation provided in the medical record that Patient 1 was unable to use a bedpan or commode. A third sticker regarding the medical necessity of central lines	A 749	Continued From page 123 Finding 1: Actions Taken: 1. The Director of Infection Prevention sent a letter and a copy of the policy titled "Urinary Catheter: Preventing Infections" to physician members of the Medical Staff for their review and to educate them on the requirement that central lines and foley catheters be assessed for medical necessity and documented on the medical necessity stickers every 24 hours to prevent the potential of creating the risk of unnecessary catheter use and the attendant risks of pain and infection. 2. The Infection Control Practitioners (ICP) or designee are making daily rounds and reviewing random records to assist with obtaining compliance with physicians completing the medical necessity stickers for central lines and foley catheters. If a sticker is not completed, the ICP or qualified designee contacts the physician to discuss the medical necessity issues. 3. The Director of Infection Prevention met with the Nurse Managers to discuss the importance of nurses encouraging physicians to complete the medical necessity sticker. 4. The CMO spoke with the physician for Patient 1 about completing medical necessity stickers.	9/6/11 9/6/11 9/1/11 9/6/11

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 749	<p>Continued From page 125</p> <p>walls produced more brown, black residue. The finding was verified by the Director of Nutritional Services (DNS) and the Kitchen Supervisor (KS).</p> <p>During a concurrent interview with the DNS, she stated that the hospital used an outside service to clean the interior of the ice machine on a quarterly basis. She further stated that the Food Service Manager (FSM) checked the cleanliness of the ice machine and documented her checks on a weekly sanitation checklist. She stated that the residue was not noted on these weekly checks. She was unable to explain how the build-up of the residue was not detected before this observation.</p> <p>During an observation and concurrent interview with the Director of Plant Operations (DPO) on July 25, 2011, at 2:40 p.m., he confirmed that the hospital used an outside service to clean the interior of the ice machines. He further stated that the last time the machine was cleaned by this service was in June of this year. Again, a clean, white paper towel swipe of the interior of the ice machine produced more brown, black residue along the ice contact surface of the chute where the new ice drops into the storage bin. He stated that the residue was not desirable and further stated, "I'm not OK with that, it is not good." He stated that he confirmed the cleanliness of the ice machine after the outside company cleaned it to verify it was clean in June.</p> <p>Also during this observation, the ice scoop was noted to be stored sitting on the ice inside the ice machine. During a concurrent interview with the DNS, she stated that the scoop should be stored outside the ice machine in a container on the wall</p>	A 749	<p>Continued From page 125</p> <p>Nutritional Services and Director of Plant Operations, reviewed the contract with the contracted ice machine cleaning company, and reviewed the manufacturer's instruction manual for the ice machine.</p> <p>2. The hospital replaced the ice machine in the kitchen at the Rancho Springs campus.</p> <p>3. The Director of Plant Operations increased the cleaning service to the ice machines monthly. The monthly cleaning schedule is in place.</p> <p>4. The Nutritional Staff shall inspect the ice machine daily, both inside and outside, to observe for residue. If residue is noted, an immediate cleaning will be performed. Ice scoops shall not be stored inside the ice machine. The Nutritional Staff was inserviced on the process for inspecting the ice machine and storing ice scoops outside the machine.</p> <p>Compliance and Monitoring:</p> <p>The Director of Nutritional Services or qualified designee shall perform weekly inspections of the ice machines for residue and take immediate corrective action. The Infection Control Practitioner shall also make rounds at least weekly to observe the ice machines inside and outside for residue. Compliance shall be reported to the hospital PI Council, who will report through the hospital Quality Oversight Structure to the Board of Governors monthly. This review will occur for 3 months and then be re-evaluated.</p> <p>Persons Responsible:</p> <p>Director of Infection Prevention Director of Nutritional Services</p>	8/27/11 8/27/11 7/28/11 9/6/11	

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A 749	<p>Continued From page 126 adjacent to the ice machine.</p> <p>A review of the hospital's policy titled, "Ice Handling" (dated May 2011) stated that the purpose of the policy was to provide criteria to prevent contamination during the process of handling ice. It further stated that the Nutritional Services Department prepared, handled and served ice under sanitary practices and procedures. It stated that the ice machines were thoroughly cleaned on a quarterly basis in the kitchen. It also stated that the ice scoop was to be stored on the outside of the ice machine.</p> <p>A review of the manufacturer's instruction manual for the ice machine, dated December 11, 2006, revealed that the manufacturer recommended cleaning the unit at least once a year, but more frequent cleaning may be required in some existing water conditions.</p> <p>A review of the contracted ice machine cleaning company's Service Order Invoice, dated June 9, 2011, showed that service was performed for the ice machine located in the dietary department at RSMC on that date. It stated that the ice machine was chemically cleaned, flushed and sanitized during this service.</p> <p>During an interview with the technician from the contracted ice machine cleaning company, who performed the cleaning of the ice machine, on July 26, 2011, at 8:05 a.m., he stated that it was his experience that some ice machines would have a buildup of a brown, black substance in as little as 2 days after he serviced the machine. The buildup depended on the conditions of the environment surrounding the ice machine.</p>	A 749		

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A 749	Continued From page 127 During an interview with the Infection Control Practitioner (ICP) on July 27, 2011, he stated that he conducted weekly sanitation rounds with the FSM which included observation of the ice machine in RSMC kitchen. He further stated that inspection of the ice machine consisted only of the cleanliness of the outside of the ice machine. He stated that during the weekly sanitation rounds, the interior of the ice machine was not observed. He was unable to state how the ice contact surface of the ice machine could be monitored by observing only the outside of the machine. A review of the hospital's policy titled, "Infection Control - Nutritional Services" (dated April 2011) revealed that the purpose of the policy was to maintain a clean and sanitary work environment, including equipment, for the safe and sanitary handling of food supplies in accordance with health department standards. The policy acknowledged that maintenance of high sanitation standards in a hospital dietary department was of utmost importance due to the extra responsibility which was placed on a health care institution who served a highly susceptible population. It further stated that the Nutritional Services staff was responsible for the routine cleaning of the ice machine which included the reachable interior, exterior surface areas and the ice scoop dispenser of the ice machine in the kitchen.	A 749		
A1112	482.55(b)(2) QUALIFIED EMERGENCY SERVICES PERSONNEL There must be adequate medical and nursing personnel qualified in emergency care to meet	A1112	482.55(b)(2) QUALIFIED EMERGENCY SERVICES PERSONNEL	

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A1112	<p>Continued From page 128 the written emergency procedures and needs anticipated by the facility.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure adequate nurse staffing in the ED to care for Patient 3. This failed practice could potentially result in substandard healthcare for Patient 3.</p> <p>Findings:</p> <p>The medical record of Patient 3 was reviewed on July 26, 2011, through August 2, 2011. Patient 3 came to the ED on [REDACTED] 2011, at 9:42 p.m. via ambulance with complaints of weakness and leg pain. The medical record showed that lab samples were obtained, and a critical potassium level of 8.8 mmol/L (normal 3.6-5.1 mmol/L, elevated potassium can cause fatal heart rhythms) was reported on January 15, 2011, at 12:50 a.m. MD 2 ordered Kayexalate, calcium gluconate, insulin and dextrose in water (medications to reduce potassium or to reduce the effect of elevated potassium) between 1:18 a.m. and 1:20 a.m. However, the medical record showed that the medications were not administered until hours later (Kayexalate at 4:30 a.m., calcium gluconate at 4:05 a.m., insulin at 3 a.m., and dextrose and water at 3:03 a.m.).</p> <p>The medical record for Patient 3 showed disposition notes by the ED physician (MS 2), at 1:23 a.m., indicating that care was being transferred to MS 7, the admitting physician. Admitting orders, including medication orders for Albuterol and Atrovent for shortness of breath, aspirin, Lopressor, Lasix, Kayexalate,</p>	A1112	<p>Continued From page 128</p> <p>Actions Taken:</p> <ol style="list-style-type: none"> Administration and Nursing Leadership reviewed the "Assessment and Reassessment in the Emergency Department" and "Patient Flow and Capacity Management: Hospital Wide" policies and procedures. They also reviewed the 2/8/11 ED Quality Review Committee investigation of the incident. The ED nurses received ongoing education and support in January at the time of the hospital's upgrade to the ED electronic medical record system. New hires receive individualized computer training on the ED electronic medical record system, which is validated by the ED Nurse Educator or qualified designee. In addition, should any upgrade to the ED electronic medical record system occur, the ED Nurse Educator or qualified designee inservices the nursing staff and validates their competency to the upgraded system. All ED nurses were re-educated on the responsibility for documenting nursing assessments, including vital signs in accordance with established guidelines. Changes in the patient's condition are immediately reported to the physician and orders carried out. Special emphasis was also placed on complying with physician's orders (e.g., medication administration) in accordance with hospital policy. ED nurses are reviewed on proper completion of the medical record through concurrent review and ongoing retrospective chart review. All Nursing supervisors were re-inserviced on the "Patient Flow and Capacity Management" policy, emphasizing their role in responding to the needs of the nursing staff when patient care needs change and additional staff is required. The Nursing Supervisor shall be notified at times when 	<p>7/28/11</p> <p>9/6/11</p> <p>9/6/11</p>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2011
NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM			STREET ADDRESS, CITY, STATE, ZIP CODE 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
A1112	<p>Continued From page 130</p> <p>assessments at 3:40 a.m., and at 4:10 a.m.</p> <p>During an interview with NM 7 on July 26, 2011, at 9:30 a.m., she stated that the vital signs of Patient 3 at 12:50 a.m. were very concerning, and that waiting until 2:30 a.m. to recheck them was too long. She stated for patients with critical conditions, the vital signs should be checked as often as every 15 minutes.</p> <p>During a review on July 29, 2011, of the facility policy, "Assessment and Reassessment in the Emergency Department " (issued May, 2010, reviewed September, 2010), the policy read in part, If a patient (Adult or Pediatric) is unstable, reassess blood pressure, pulse, respirations and condition at least every fifteen (15) minutes until stable."</p> <p>The orders of MS 7, telephoned to ED RN 2 at 1:23 a.m., indicated the doctor was to be informed of abnormal vital signs, including a blood pressure above 180, a heart rate above 100, and for chest pain. At 2:30 a.m., Patient 3's blood pressure was 213, and her heart rate was 101, and she had 9 (out of a scale from 1 to 10, 10 being worst) chest pain, but there was no evidence that MS 7 was informed of those abnormalities. There was no evidence that MS 7 was contacted regarding Patient 3's deteriorating condition until 4:58 a.m., when the nurse called the admitting physician "to consider changing DOU (unit providing a level of care between a regular medical bed and the intensive care unit) to ICU status."</p> <p>Orders to admit Patient 3 to the DOU/intermediate care unit were written by the</p>	A1112		

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

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A1112	<p>Continued From page 131</p> <p>admitting physician at 1:20 a.m. At 3:56 a.m., a bed in the intended unit was available, however, by that time, according to bed control documents, the patient had become more unstable due to respiratory distress, and required an ICU bed. The medical record showed that at 4:58 a.m., more than an hour later, the nurse called the admitting physician "to consider changing DOU to ICU status." The medical record showed that Patient 3 remained in the ED.</p> <p>During an interview with NM 7 on July 26, 2011, at 9 a.m., she stated the ED boards ICU patients at times. She stated once the patient is admitted, the admitting physician assumed care of the patient, but the ED nurse continued nursing care.</p> <p>According to the medical record the ED physician, MS 2, was walking by the bed of Patient 3 in the ED and noted that she had agonal (dying) respirations. Patient 3 was the subject of a code blue (emergency response) at 5:50 a.m., and was pronounced dead at 6:20 a.m.</p> <p>During an interview with the Chief Nursing Officer, (CNO) on July 27, 2011, at 3:20 p.m., she stated Patient 3's care was sent to the ED for review by that department's nursing leadership. She stated that she thought ED RN 1 had not been documenting the patient's condition because he had difficulty using the new computer system. When asked if ED RN 1 was provided with additional education regarding use of the computer system, she stated that the nurses had already been educated on the use of the computer system at that time.</p> <p>Documentation of the facility's interview, dated</p>	A1112		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A1112	<p>Continued From page 132</p> <p>February 9, 2011, with ED RN 1 regarding Patient 3's care was reviewed on July 27, 2011. At that time, ED RN 1 explained the delays in care given to Patient 3 by saying he was unfamiliar with the new (in place for 10 days) computer system, and that he was very busy the night he cared for Patient 3. He stated he notified the charge (supervising) nurse that he needed assistance, but did not receive adequate assistance.</p> <p>There was no evidence that ED RN 1's difficulty using the computer system was identified or addressed pursuant to a review of the care given to Patient 3 s on January 14, 2011, and January 15, 2011. During an interview with the ED Manager on July 26, 2011, at 9:30 a.m., she stated that ED RN 1 still worked in the facility's ED.</p> <p>A written interview of the charge nurse by the ED Manager on February 10, 2011, was reviewed on July 27, 2011. In the interview, the charge nurse on the night of Patient 3's ED stay recalled that ED RN 1 had asked for help several times due to his "heavy assignment."</p> <p>NM 7, in an interview on July 26, 2011, at 9:30 a.m., was asked regarding processes for nursing oversight in the ED. She stated that the charge nurse provided oversight by making rounds every 4 hours. She stated that the charge nurse provided assistance or obtained assistance to meet patient care needs. She was not able to explain why Patient 3's care had not received oversight by the charge nurse.</p> <p>The facility process for coping with increased patient care needs in the ED was reviewed with</p>	A1112		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A1112	<p>Continued From page 133</p> <p>the ED Manager on July 26, 2011, at 9:30 a.m.. She stated that the charge nurse should respond to the need for the patient to be changed to critical status, and for the need for additional nurse time for the patient. NM 7 stated that when the charge nurse was unable to provide the required assistance, nursing staff was to go up the chain of command to obtain needed assistance.</p> <p>In an interview with the CNO on July 26, 2011, at 10 a.m., she stated the ED staffing during patient care surges was a process that had been informally in place for a year.</p> <p>During an interview with the ED Director on July 29, 2011, at 8:45 a.m., she stated that the chain of command had not been activated while Patient 3 was in the ED. She was not able to explain why/ ED RN 1 did not activate the chain of command to obtain assistance. She stated that the nurse staffing during Patient 3's stay on January 14, 2011, to January 15, 2011, in the ED had not been subject to analysis.</p> <p>During a review of the facility policy, Patient Flow and Capacity Management: Hospital Wide (revised December, 2010, reviewed March, 2011) on July 29, 2011, conditions that signified a "yellow" status included, "Patients are holding in the ED or Post Anesthesia Care Unit.," and "ED wait time to bed > (greater than) 2 hours. "The actions to be taken during a "yellow" status read in part, "Call Emergency bed Huddle after paging Joint Leadership... Charge nurse to take patients." and "Per Diem (paid by the day) and regular staff to be called in."</p>	A1112			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A1112	Continued From page 134 During an interview with the CNO on July 29, 2011, at 8:45 a.m., she reviewed hospital records from the night of [REDACTED] 2011, and the morning of [REDACTED] 2011, when Patient 3 was in the ED, and stated no emergency bed huddle had been held.	A1112		
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K 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health, Life Safety Code Unit, during an Full Life Safety Code Survey of the facility utilizing the NFPA (National Fire Protection Association) 101, 2000 Edition (New) of the Life Safety Code. The facility was surveyed under 42 CFR 482.41(b)(1) for General Acute Care Hospital. K3 BUILDING 03: WOMEN'S CENTER-EMERGENCY DEPARTMENT K6 PLAN APPROVAL: 1/14/2010 K7 SURVEY UNDER: 2000 NEW TYPE OF STRUCTURE: TWO STORY BUILDING, TYPE I, FULLY SPRINKLERED Representing the California Department of Public Health Life Safety Code Unit: Surveyor: 29626 Census: Rancho Springs Medical Center and Women's Center/Emergency Department - 81	K 000		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 29626 Based on observation, the facility failed to	K 029	NFPA 101 LIFE SAFETY CODE STANDARD Actions Taken: 1. The Director of Plant Operations reviewed the environmental rounding checklist and validated an assessment of fire and smoke barriers, including self-closing mechanisms on doors was included. 2. The Plant Operations Manager installed a self-closing mechanism on the door of the Rancho Springs ED Manager's office. He inspected all offices on both campus settings	8/30/11 9/1/11

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

TITLE

(X6) DATE

CEO/Managing Director

9.20.11

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

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K 029	Continued From page 1 maintain its hazardous areas by not providing a self-closing mechanism on doors to hazardous rooms. This affected 1 of 7 smoke compartments at Rancho Springs Women's Center/Emergency Department. This had the potential to allow the rapid spread of smoke and fire, resulting in injury to patients, visitors and staff. Findings: During a tour of the facility with the Plant Operations Manager, Engineer II, and the Director of Plant Operations on July 27, 2011, hazardous areas were observed. Women ' s Center/Emergency Department At 9:01 a.m., the Manager's Office located on the 1st Floor in the Emergency Department, did not have a self-closing mechanism installed on the door. The room contained combustible products such as paper files and cardboard boxes filled with files that covered approximately fifty percent of the room.	K 029	Continued From page 1 to validate doors had a self-closing mechanism if the office contained combustible materials. Compliance and Monitoring: The Plant Operations Managers or qualified designee conducts monthly environmental safety rounds utilizing the environmental check-list to evaluate compliance for Life Safety requirements, including self-closing door mechanisms. Corrective action is taken immediately for any deficiencies. The Director of Plant Operations aggregates the data, interventions taken, and presents the findings to the Environment of Care Committee for any further action on a monthly basis. The Environment of Care Committee reports on compliance through the hospital Quality Oversight Structure to the Board of Governors on a monthly basis. Person Responsible: Director of Plant Operations	9/6/11 and ongoing
K 051	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of	K 051	NFPA 101 LIFE SAFETY CODE STANDARD Actions Taken: 1. The Plant Operations Manager immediately cleared the obstruction blocking the view of the manual fire alarm pull on the First Floor Women's Center/Emergency Department. An informational memo was provided to all volunteers, detailing the location of the manual fire alarm pull stations throughout both campus facilities. 2. The Director of Plant Operations reviewed the environmental rounding checklist and validated an assessment of manual fire alarm	7/27/11 9/1/11

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K 051	<p>Continued From page 2</p> <p>maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6</p> <p>This STANDARD is not met as evidenced by: Surveyor: 29626 Based on observation, the facility failed to ensure the manual fire alarm pull stations were easily accessible to allow for quick activation of fire alarm. This was evidenced by one manual fire alarm pull station that was obstructed from view on the First Floor Women's Center/Emergency Department. This could result in a delayed response to a fire and increase the risk of injury to patients, visitors and staff.</p> <p>Findings:</p> <p>During a tour of the facility with the Plant Operations Manager and the Director of Plant Operations on July 27, 2011, the fire alarm system was tested and observed.</p> <p>Women's Center/Emergency Department At 9:35 a.m., the manual fire alarm pull station in the lobby located on the 1st Floor of the Women's Center/Emergency Department was obstructed from view. A stand that contained a tissue box, two mask boxes, and a hand sanitizer was placed in front of the fire alarm pull station. When the volunteer working at the front desk was interviewed and asked if they could point to the nearest manual pull station, they could not locate the fire alarm pull station that was obstructed.</p>	K 051	<p>Continued From page 2</p> <p>pull stations and accessibility were included.</p> <p>Compliance and Monitoring:</p> <p>The Plant Operations Managers or their qualified designee conduct monthly environmental safety rounds utilizing the environmental check-list to evaluate compliance for Life Safety requirements, including accessibility of manual fire alarm pulls. Staff members and volunteers are queried on the locale of the pull stations within the area and provide further clarification if necessary. Corrective action is taken immediately for any deficiencies. The Director of Plant Operations aggregates the data, interventions taken, and presents the findings to the Environment of Care Committee for any further action on a monthly basis. The Environment of Care Committee reports on compliance through the hospital Quality Oversight Structure to the Board of Governors on a monthly basis.</p> <p>Person Responsible: Director of Plant Operations</p>	9/6/11

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