

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

PRINTED: 04/12/2010
FORM APPROVED
OMB NO. 0938-0301

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 01/19/2010
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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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ID# / 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)	CORRECTED BY DATE
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A 500	<p>Continued From page 68</p> <p>what they should do if there was pharmacist/physician disagreement as to whether the use of this medication was contraindicated in a given patient</p> <p>On 1/15/10 at 1148 hours during an interview of M32, he stated that fentanyl patches were not indicated for the management of post-operative pain or for use non-opioid tolerant patients. He stated that the phrase "Orders for Transdermal Fentanyl Patches (TFP) will be reviewed by a pharmacist for appropriate patient selection and dose" found in the hospital fentanyl patch policy meant that the pharmacist was to check to see if the patient was opiate tolerant. He stated that this policy made no mention of the seven day requirement used to determine opioid tolerance (as stipulated in the product labeling). He stated that E106 did not have proper guidance from this policy.</p> <p>B. On 1/11/10 at 0915 hours, during an interview of M10, he stated that there was only one cabinet in the pharmacy at RSMC and it was used to compound IV chemotherapeutic medications and standard IVs. He stated they had a chemotherapeutic order about once a week and after the chemotherapeutic medication had been compounded it was cleaned out. He stated they used an American Society of Health System Pharmacists recommended product to clean out this cabinet. During a visit to the pharmacy at 1059 hours on 1/11/10, the cabinet proved to be a closed cabinet with an antechamber into which IV medications and solutions could be placed and the outer door closed. Then the operator could stick his arms into a sleeve and glove assembly, which was built into the front wall of the cabinet, and remove the products from the antechamber.</p>	A 500		
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A 500	<p>Continued From page 69</p> <p>via an inner door into the main body of the cabinet where the compounding took place.</p> <p>On 1/13/10 at 1633 hours a review of the manual that came with the cabinet indicated the model number of the cabinet was Microsphere 6X2 and that it was manufactured by IsoTech Design.</p> <p>On 1/14/10 at 0738 hours during a telephone interview of DSM1 from IsoTech, he stated that the Microsphere cabinet was not designed for compounding IV chemotherapeutic medications and a hospital should not use it for that purpose. He stated that the company is very clear about this when they sell it to an end user. He said it was designed to compound sterile products. He stated that they made a cabinet called Chemosphere that was intended to be used for compounding IV chemotherapeutic products. He stated that the Microsphere cabinet was a positive pressure cabinet while the Chemosphere cabinet was a negative pressure cabinet.</p> <p>On 1/14/10 at 1655 hours review of an undated letter to M10 documented that IsoTech Design had "congratulated" M10 on his purchase of a Chemosphere cabinet. This letter was produced by M44 at 1655 hours on 1/14/10.</p> <p>9. On 1/11/10 at 0915 hours, during an interview of M10, he stated that there was only one cabinet in the pharmacy at RSMC and it was used to compound IV chemotherapeutic medications and standard IVs. He stated they used an American Society of Health System Pharmacists recommended product to clean out this cabinet. At 1058 hour on this date, inspection of the pharmacy indicated they had a product called Surface Safe that staff stated was used to clean</p>	A 500		
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A 500 Continued From page 70 A 500

the cabinet after IV chemotherapeutic agents were compounded in the cabinet.

On 1/14/10 at 1636 hours during an interview of M44, he stated that he had E111 compare the chemotherapeutic medications that had been ordered by the pharmacy to compound in the Microsphere cabinet to the medications listed on the Surface Safe product labeling and she found that one of the medications used by the hospital, rituximab, was not listed on the Surface Safe product labeling. He stated that he called the company that made Surface Safe and they could not tell him if it inactivated Rituximab.

A review, at this time of a list of chemotherapeutic medications that had been ordered by the hospital from 1/1/09 through 1/1/10 indicated that a 100 mg and a 500 mg vial of rituximab had been ordered on 11/13/09 and again on 12/10/09. He stated that the Microsphere cabinet had been installed at the end of October 2009. He stated that chemotherapeutic medications were only prepared when a physician had written an order for the medication. He said the orders were written in advance so the pharmacy would have time to order the drug. Therefore, these rituximab vials were ordered and used to compound IV chemotherapeutic solutions in the pharmacy and no evidence was provided that the pharmacy staff had an agent that could deactivate this medication in the Microsphere cabinet before it was used to make standard IVs

10. On 1/11/10 at 0915 hours, during an interview of M10, he stated that there was only one cabinet in the pharmacy at RSMC and it was used to compound IV chemotherapeutic medications and standard IVs. He stated they used an American

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A 500	<p>Continued From page 71</p> <p>Society of Health System Pharmacists recommended product to clean out this cabinet At 1058 hours on 1/11/10, inspection of the pharmacy indicated they had a product called Surface Safe that staff stated was used to clean the cabinet after IV chemotherapeutic agents were compounded in the cabinet</p> <p>On 1/13/10 at 1535 hours a review of the product labeling removed from a box of Surface Safe indicated the following:</p> <ul style="list-style-type: none"> - The inactivating agent (sodium hypochlorite) in a soap solution was contained in "towelette Number 1" and an agent used to neutralize the inactivating agent (sodium thiosulfate) was contained in "towelette Number 2." - The product was supplied in cartons containing 15 boxes each with each box containing a Number 1 and Number 2 towelette. * It documented that " preliminary studies suggest that there is no universal inactivating substance for the different classes of cancer chemotherapeutic drugs " * The towelettes were to be applied in numerical order and contained enough solution to treat two square feet of surface area. <p>On 1/13/10 at 1602 hours during an interview of M44, he stated pharmacy staff used the procedure in the Surface Safe product labeling to decontaminate the cabinet</p> <p>On 1/13/10 at 1604 hours during an interview of E108 she stated the cabinet contained 12 square feet of surface area and she used six pairs of towelettes to decontaminate the interior of the cabinet including the antechamber. She said that on average, the hospital admitted one patient/week that was using a chemotherapeutic</p>	A 500	

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medication, but the course of treatment could range from one to seven days with the average being three days. She stated that sometimes they would go a week without making an IV chemotherapeutic medication and then could have a run where an IV chemotherapeutic medication was made for five or six days straight

On 1/13/10 at 1652 hours during an interview of E112, he stated he did not know the square footage of the cabinet but he used six pairs of towelettes to decontaminate the interior of the cabinet,

On 1/14/10 at 1721 hours a re-inspection of the Microsphere cabinet in the RSMC pharmacy indicated that it contained 10 plastic bins containing hypodermic needles, syringes, and alcohol wipes used to compound IV solutions including IV chemotherapeutic agents. During an interview of E108, she said that pharmacy staff did not decontaminate these bins or supplies after compounding an IV chemotherapeutic medication

On 1/19/10 at 1324 hours during a telephone interview of M44 he stated that the Microsphere cabinet contained 79.5 square feet of interior surface space, including the floor and walls, (but not the ceiling) of the antechamber and the main cabinet including the sleeves and gloves in the main working area of the cabinet. He stated his staff had told him that they used six pairs of towelettes to decontaminate the cabinet. Based on the manufacturer's specification in the product labeling, he stated this would be enough to decontaminate only 15 percent of the interior of the Microsphere cabinet

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11. On 1/13/10 at 1739 hours a review of the policy and procedure entitled Preparation of Antineoplastics indicated the following:

- * The pharmacy would establish and maintain policies and procedures for the preparation and transport of chemotherapeutic medications
- * The purpose of the policy was, "To ensure a safe and optimal process for the preparing, dispensing, transporting, chemotherapy"
- * Personnel involved in the handling of chemotherapeutic medications would undergo an orientation program, testing, and certification which would be documented in the employee's educational record
- * Part of this orientation training would include a review of this policy, a review of an educational video tape entitled "Safe Handling of Chemotherapy and Hazardous Drugs and "... supervision by trained personnel." It did not specify who these trained personnel were or how they were qualified to provide this supervision.
- * All chemotherapeutic agents would be prepared in a Class II vertical-flow biologic safety cabinet (the Microsphere is an ISO Class 4 cabinet as per Iso Tech Design specifications provided by DSM1 on 1/14/10 at 0815 hours via an e-mail).
- * It did not provide any description of the deactivating product, Surface Safe, or a procedure on how to use it.

On 1/14/10 at 1632 hours during an interview of M44, he stated that he did not think there was pharmacist-directed training of the pharmacy technicians with regard to decontamination of the Microsphere cabinet. He stated there was no hands-on demonstration of competency. He stated that he could not locate the chemotherapy training video. He stated that the Pharmacy Techs took a competency exam regarding the

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A 500	<p>Continued From page 74</p> <p>compounding of sterile products but it was not specific to chemotherapeutic medications. He produced a list showing documentation that 13 pharmacy staff had watched the "Chemo Preparation Video." Each name had a date after it and the range was from 11/25/06 through 11/27/07.</p> <p>On 1/15/10 at 1142 hours during an interview of M44, he stated that he did not have chemotherapy specific competencies for his Pharmacy Technician staff and he still could not locate the training video.</p> <p>No evidence was provided that the hospital-developed pharmacist driven policies and procedures that mirrored the current working conditions in the pharmacy, that pharmacy staff was evaluated annually as per the policy and procedure, and that competency criteria had been developed to evaluate the ability of the Pharmacy Technicians to compound chemotherapeutic agents and decontaminate the cabinet.</p> <p>12. Malignant Hyperthermia (MH) is a life threatening emergency associated with the use of succinylcholine (used to relax muscles during surgery) and anesthetic gases used during surgery. It is characterized by a rapid rise in body temperature that can be life threatening, and can result in irregular heart beats. The Malignant Hyperthermia Association of the United States (MHAUS), a nationally recognized organization regarding the treatment of MH has published recommended list of medications to be contained in an MH emergency kit. It recommends that the cart contain lidocaine (used to treat dangerous irregular heart rhythms) and calcium chloride (used to counteract the effect of high potassium).</p>	A 500	

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A 500	<p>Continued From page 75</p> <p>levels on the heart that can potentially occur during a case of MH)</p> <p>a. On 1/11/10 at 1517 hours an inspection of the MH Cart in the RSMC PACU indicated that it contained two 20 ml vials of lidocaine 2% labeled by the manufacturer as indicated for local nerve blocks. Lidocaine is available in pre-loaded syringes indicated for use in the treatment of dangerous irregular heart rhythms. The cart did not contain any calcium chloride.</p> <p>During an interview of M44 at 1517 hours on 1/11/10, he could give no reason why calcium chloride had been excluded from the supply. The next day, 1/12/10, at 0957 hours he stated that there was no reason to exclude calcium chloride from the supply and stated he felt it should be added to the MH medication supply.</p> <p>On 1/12/10 at 0936 hours a review of the policy and procedure entitled Malignant Hyperthermia (issued 4/97 and last revised 10/09) indicated that it listed the use of calcium chloride to treat life threatening high potassium levels.</p> <p>b. On 1/12/10 at 1442 hours an inspection of the MH Cart in the IVMC PACU indicated it contained two 20 ml vials of lidocaine 2% labeled by the manufacturer for use as a local nerve block.</p> <p>On 1/19/10 at 1324 hours during a telephone interview of M44 he stated that lidocaine was put on the MH Cart to treat heart arrhythmias (irregular heart rhythms). He stated that the 20 ml vial observed in the MH Carts on the RSMC and IVMC MH Carts was the wrong product and that 5 ml pre-filled syringes of lidocaine should have been placed in these emergency supplies.</p>	A 500	

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A 500	<p>Continued From page 76</p> <p>He stated that he felt that this was due to a typographical error on the content list for the lidocaine listing</p> <p>13. On 1/12/10 at 0936 hours a review of the policy and procedure entitled Malignant Hyperthermia (issued 4/97 and last revised 10/09) indicated that the content list contained in the policy did not match the content list contained in the medication tray in the MH Carts on both the RSMC and the IVMC MH Carts. Inspection of both of these supplies on 1/11/10 at 1517 hours at RSMC and on 1/12/10 at 1442 hours at IVMC indicated that the medication tray contents on both of these carts matched the content list found inside these trays and that both content lists were identical to each other. The policy content list documented the supply contained six vials of procainamide (used to treat dangerous irregular heart rhythms) but this was not in the medication tray. The policy content list documented that the medication tray contained two 40 mg vials of furosemide (used to increase urine flow in acutely failing kidneys) while the tray actually contained four such vials.</p> <p>14. On 1/1/05 the CDPH (then known as the Dept of Health Services) released to all California Hospitals an All Facilities Letter (AFL 05-02) regarding the "Storage and Use of Emergency Medications." It documented that the hospitals must ensure that approved policies and procedures were developed establishing the content of emergency medication supplies. It documented that these policies should be current and based on clinical standards of practice.</p> <p>On 1/13/10 at 1059 hours during an interview of M10 in the RSMC ED he stated that there was no</p>	A 500			

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policy and procedure that established the contents of the Adult or Pediatric Crash Carts.

15 On 1/13/10 at 1026 hours during an interview of E111 she stated that an intubation tray containing medications for rapid intubation (insertion of a tube into the throat to facilitate breathing) was maintained in the E.D. She stated there was an ICU Intubation tray that was identical to the ED tray except midazolam (a sedative used to produce loss of memory of unpleasant procedures) was not included in the ICU tray.

A review of content lists for the RSMC Intubation Tray stored in the ED and the RSMC-ICU Intubation tray indicated that both contained atropine (used to treat slowly beating hearts), lidocaine (used to treat dangerous irregular heart rhythms), pancuronium, succinylcholine, and vecuronium (these last three are muscle relaxants used to facilitate insertion of the breathing tube), etomidate (use to induce anesthesia), and in the ED tray, midazolam.

A review of the content list for the IVMC Emergency Department Rapid Intubation tray provided by M32 at 1059 hours on that date indicated that it contained atropine, lidocaine, succinyl choline, vecuronium, etomidate, and midazolam.

During an interview of M10 at this time he stated there were no policies and procedures that stipulated what the contents of these trays were to be and no policies and procedures for the use of these trays.

16 On 1/11/10 at 1429 hours during an

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A 500	<p>Continued From page 78</p> <p>inspection of the only warmer in the RSMC Surgery Department, the top compartment temperature, where IV and irrigation solutions were stored was documented to be 96 degrees Fahrenheit per the electronic readout visible on a digital display outside the warmer.</p> <p>At 1500 hours E160 measured the temperatures in five of these solutions in this top cabinet using a "Fluke 62 Min. IR Thermometer" (measured the temperature of individual solutions and displayed it digitally) and they were as follows:</p> <ul style="list-style-type: none"> * One 1000ml IV bag of NS (normal saline) measured at 39.6 deg. C (103.3 deg. F) * One 1000 ml IV bag of NS measured at 40.8 deg. C (105.4 deg. F) * One 1000 ml IV bag of Lactated Ringers measured at 46.8 deg. C (116.2 deg. F) * One 1000 ml IV bag of Lactated Ringers measured at 45.4 deg. C (113.7 deg. F) * One 1000 ml plastic pour bottle of NS for irrigation measured at 42 deg. C (107.6 deg. F) <p>On 1/12/10 at 0916 hours a review of the policy and procedure entitled Warmers: Safe Storage of Medications, Solutions, and Blankets indicated that solutions were not to be stored at temperatures higher than 93.6 deg. F</p> <p>On 1/12/10 at 0902 hours a review of a letter from the manufacturer documented that IV solutions could be stored at temperatures up to 40 deg. C for four weeks.</p> <p>On 1/12/10 at 1648 hours a review of a letter from the manufacturer provided by M32 indicated that the irrigation solutions in plastic pour bottles could be stored at temperatures up to 40 deg. C for four weeks.</p>	A 500	

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17. On 1/11/10 at 1429 hours an inspection of the only warmer in the RSMC Surgery Department indicated that IV and irrigation solutions were stored at temperatures above those recommended by the manufacturer and the hospital policy and procedure. During an interview of M10 at this time, he stated that pharmacists did not inspect the warmers.

On 1/12/10 at 1558 hours one of two warmers in the IVMC Surgery Department was inspected. During an interview of M36 at this time, she stated she had not seen pharmacists inspect the warmers.

California Code of Regulations, Title 22, Section 70263(q)(10) stipulates that medications stored in nursing units shall be inspected at least monthly by the pharmacist.

18. On 1/12/10 at 1417 hours while inspecting the IVMC pharmacy, inspection of a bin containing Xopenex (stored in unit dose pillows for use in inhalation nebulizer machines in order to open restricted airways) indicated that one foil pouch containing seven unit dose pillows was open and two more pillows were stored openly in the bin outside of the foil pouch in which the manufacturer packaged them. A label on the carton that held the foil pouches documented that these vials were to be used within two weeks if stored in an open foil pouch and within one week if stored outside of the foil pouch.

During an interview of E109 at this time he stated that the foil pouches were to be dated when opened (so the more rapid expiration date could be tracked). He stated that the pillows outside

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED 01/19/2010
NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 75500 MEDICAL CENTER DRIVE MURRIETA, CA 92562	
JCAH ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ICD PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
A 500	Continued From page 80 the foil pack should have been discarded. There was no date on the foil pack. During an interview of M32 at this time he stated that the foil pouches of Xopenex were to be dated by staff when opened. He stated that it was a "standard of practice" to do this in the IVMC Pharmacy. 19. On 1/15/10 at 1530 hours, the IVMC ED was toured. During the inspection of the adult crash cart, one ampule of epinephrine 1:10,000 1mg/10ml was missing according to the content list. A concurrent interview with E161 disclosed the pharmacy was responsible to refill the medications in the crash cart. The medication record sheet showed the cart was prepared and inspected by the pharmacist on 1/9/10.	A 500	
A 505	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 document and policy and procedure review, the hospital failed to ensure that expired medications to treat infection, asthma and paralyze muscles in people undergoing operations, wound dressings, intravenous normal saline solution, outdated scrub sponges, mislabeled medications and unusable medications in the intubation trays stored outside recommended storage temperatures and IV solutions in the surgery warmers dated with marker pens were not available for patient use. The hospital failed to date IV bags after the outer covering was removed per the hospital P&P. The hospital failed to follow it's P&P regarding labeling intravenous	A 505	

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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	
(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)
A 505	<p>Continued From page 81</p> <p>medications which had the potential to prolong utilization of these medications beyond their effectiveness. These failures could potentially result in medications with altered potency and contamination.</p> <p>Findings:</p> <p>1. At RSMC, on 1/11/10 at 1100 hours, during a tour of the main pharmacy, an intravenous (IV) antibiotic medication was found in the IV room refrigerator. The medication was Gentamicin 500 milligrams in 250 milliliters of Normal Saline and found to have expired on 1/10/10. The medication was in the refrigerator and available to be dispensed to Patient #1. The DOP (Director of Pharmacy) removed the medication and said it had expired.</p> <p>2. On 1/12/10 at 1417 hours, while inspecting the IVMC Pharmacy, inspection of a bin containing Xopenex (for use in inhalation nebulizer machines in order to open restricted airways) indicated that one foil pouch containing seven unit dose pillows was open and two more pillows were stored openly in the bin outside of the foil pouch in which the manufacturer packaged them. A label on the carton that held the foil pouches documented that these vials were to be used within two weeks if stored in an open foil pouch and within one week if stored outside of the foil pouch.</p> <p>During a concurrent interview E109 stated that the foil pouches were to be dated when opened (so the more rapid expiration could be tracked). He stated that the pillows outside the foil pack should have been discarded. There was no date on the foil pack.</p> <p>During an interview of M32 at this time he stated</p>	A 505	

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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	
LHA 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)
A-505	<p>Continued From page 82</p> <p>that the foil pouches of Xopenex were to be dated by staff when opened. He stated he did not know how long these pillows had been stored in the open pouch or outside the pouch and that there was no way to determine this. He then discarded the nine pillows.</p> <p>3. On 1/11/10 at 1443 hours during an inspection of the RSMC Surgery Department, expired sponges were found in an open box labeled to contain 30 Scrub Care Sponges. The expiration dates on the sponges were 9/2007 (two years and three months prior to the survey). During an interview of M22 at this time she stated the sponges were over a "backup" sink but they potentially could be used. These sponges would be used by physicians and nurses to scrub before surgery.</p> <p>4. On 1/12/10 at 1442 hours at IVMC an inspection of the MH cart in the PACU indicated the first posted expiration date posted outside the MH Cart was 4/1/10 and the information so posted documented that the medications to expire were furosemide (used to increase urine flow) and heparin (a blood thinner). Inspection of the cart indicated the heparin vials were labeled by the manufacturer as expiring 9/2010. The expiration date for the heparin posted outside the cart was not accurate.</p> <p>5. On 1/12/10 at 1442 hours at IVMC an inspection of the MH cart in the PACU revealed seven of nine inaccurate expiration dates on the internal content list of medications stored in tray in this cart:</p> <p>a. The expiration date documented on the content list for furosemide (used to increase urine flow)</p>	A 505	

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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS CITY STATE ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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A 505	<p>Continued From page 83</p> <p>was 2/1/11. Inspection of the medication tray indicated the manufacturer's expiration date on all four of the vials was 4/1/10.</p> <p>b. The expiration date documented on the content list for amiodarone (used to treat dangerous irregular heart rhythms) was 8/2010. Inspection revealed the manufacturer's expiration date on all three vials was 2/2011.</p> <p>c. The expiration date documented on the content list for dextrose 50 percent injection was 9/2010. Inspection of the medication tray showed the manufacturer's expiration date for both pre-filled syringes was 10/2011.</p> <p>d. The expiration date documented on the content list for heparin (a blood thinner) was 4/2010. Inspection of the medication tray showed the manufacturer's expiration date on all three vials was 9/2010.</p> <p>e. The expiration date documented on the content list for lidocaine 2% was 2/1/11. Inspection of the medication tray indicated a manufacturer's expiration date for both vials was 9/1/10.</p> <p>f. The expiration date documented on the content list for mannitol 20% IV solution was 1/1/11. Inspection of the medication tray indicated a manufacturer's expiration date on both IV bags was 6/1/10.</p> <p>g. The expiration date documented on the content list for the IV bags of sterile water for injection (used to reconstitute the dantrolene used to treat MH) was 2/2012. Inspection of the medication tray indicated a manufacturer's expiration date on both IV bags was 4/2011.</p>	A 505		
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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS (CITY, STATE, ZIP CODE) 35500 MEDICAL CENTER DRIVE MURRIETA, CA 92562
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A 505 Continued From page 84

A 505

The content list serves as a label for the medications in the medication tray and the inaccurate expiration dates mislabeled the medications in this tray.

6. On 1/13/10 at 1026 hours during an interview of E111, she stated that an intubation tray containing medications for rapid intubation (insertion of a tube into the throat to facilitate breathing) was maintained in the ED. She stated there was an ICU Intubation tray that was identical to the ED tray except midazolam (a sedative used to produce loss of memory of unpleasant procedures) was not included in the ICU tray.

A review of content lists for the RSMC Intubation Tray stored in the ED and the RSMC ICU Intubation tray indicated that both contained atropine (used to treat slowly beating hearts), lidocaine (used to treat dangerous irregular heart rhythms), pancuronium, succinylcholine, and vecuronium (these last three are muscle relaxants used to facilitate insertion of the breathing tube), etomidate (use to induce anesthesia) and, in the ED tray, midazolam.

A review of the content list for the IVMC Emergency Department Rapid Intubation tray provided by M32 at 1059 hours on 1/13/10 indicated that it contained atropine, lidocaine, succinylcholine, vecuronium, etomidate, and midazolam.

An inspection of the RSMC ED refrigerator indicated these intubation trays were stored in the refrigerator. Lex-Comp Online (a drug resource website) documents that injectable atropine

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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 505 Continued From page 85 A 505

lidocaine, vecuronium and etomidate should be stored at room temperature

During an interview of M10 at 1059 hours on 1/13/10, he stated he had not obtained any information from the manufacturers or from professional literature that supported the storage of these medications under refrigeration. During an interview of M32 at this time he stated that they stored the intubation kits at room temperature, not under refrigeration, at IVMC.

7 On 1/11/10 at 1419 hours an inspection of the single warmer in the RSMC Surgery Department indicated it contained 1000 ml IV bags of NS and lactated ringers solutions made by the same manufacturer. Staff had written dates on these bags with marker pens. During an interview of M22 at this time she stated that these were expiration dates

On 1/12/10 at 1558 hours an inspection of one of two warmers in the IVMC Surgery Department located in the sub-sterile room between OR 1 and OR 2 indicated it contained 1000 ml IV bags of NS and lactated ringers solutions manufactured by the same company. Staff had written expiration dates on these bags with marker pens

The manufacturer had documented in a letter dated 3/30/06 to CDPH that: "We cannot recommend the procedure (of writing on these containers with a marking pen). We cannot conclusively say that the ink that is used in the marking pens will not leach into the solution since there are no standards for the pen industry as to the type of ink that is used. The use of lime tapes for recoding data is recommended."

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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS CITY STATE ZIP/PO BOX 25600 MEDICAL CENTER DRIVE MURRIETA, CA 92562
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(R4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(42) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)
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A 505

Continued From page 86
 8. An inspection of the difficult intubation tray in the surgical suite on 1/11/10, revealed four vials of expired Anectine, a powerful paralytic drug used for intubation.

A 505

9. At IVMC on 1/12/10 at 1600 hours the outpatient service for the Wound Care Center was toured. In the treatment room, the following expired supply items were found
 * a three pack of Restore 4 inches x 4 inches wound dressing (Silver Sulfate Triacet 3 22 gm/sq) with an expiration date of 4/2009
 * One package of Puracol Plus Collagen Dressing with an expiration date of 4/2009

A concurrent interview with the Director of Wound Care Services disclosed that the Certified Hyperbaric Technicians (CHT) inspected all of the medications and biomedical products monthly. E21 monitored the CHT's inspection. The last inspection was performed in late December. E21 was unable to provide documented evidence to show the monthly inspections.

10. The hospital's policy and procedure related to large volume IV fluids showed that if the IV bag's outer protective cover was removed and the IV was not used immediately, the bag was to be dated and discarded after 30 days.

On 1/13/10 at 1100 hours, the ICU supply cart at IVMC was inspected. There were two 1000 ml bags of normal saline without a protective cover. There was no date identifying when the bags had been removed from the protective cover. During a concurrent interview with M51, she stated if the bags were opened and not used they were to be dated and discarded after 30 days.

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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 505 Continued From page 87

A 505

11. Review of the hospital P&P for the IVMC and RSMC campuses entitled IV Certification and Administration For Licensed Nurses, revision date 11/07, showed that all peripheral IVs would be labeled with the date and initials of the nurse initiating the IV. Further review of the policy also showed that all IV solutions would be changed every 48 hours, if they did not contain additives. IV solutions containing additives would be changed every 24 hours, if prepared by appropriate hospital staff. Manufactured pre-mixed IV solutions would be changed no less often than every 48 hours.

On 1/12/10 at 1000 hours, during a tour of the 2 West medical/surgical unit at the IVMC campus with M29, it was found that IV medication bags in rooms 251, 253, 259, and 252 did not have labels to show the date, time and signature of the staff who hung the IV bags. When M29 was asked why some IV medication bags were labeled with date, time, and signature of person who hung the IV and others were not, she was not able to answer and deferred the question to E32. E32 stated that IV bags were usually labeled when hung

On 1/12/10 at 1100 hours, during a tour of the 2 Central medical/surgical unit at the IVMC campus with E30, IV bags were found unlabeled in rooms 235 and 22.

On 1/12/10 at 1200 hours, during a tour of the 2 East medical/surgical unit at the IVMC campus with M30, IV bags in rooms 205, 206, 207, and 208 were not labeled. When M30 was asked about the unlabeled IV bags, he stated that he was not sure what the usual practice was and believed the nurses usually documented in the

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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 505 Continued From page 88
MAR the time and date of when IV solutions were hung. M30 added that he would find out what the practice was.

A 505

On 1/12/10 at 1245 hours, during an interview with E6 she stated that the normal practice was to document on the MAR when IVs were hung. This was not in accordance with the P&P.

A 700 482.41 PHYSICAL ENVIRONMENT

A 700

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

This CONDITION is not met as evidenced by. Based on observation, staff interview, and inspection of the building, it was determined that the facility failed to ensure the hospital was protected from fire, that all building construction and fire protection systems were maintained and tested, as required to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. The cumulative effect of these systemic problems identified during the Life Safety Code (LSC) and Health Full Medicare Validation survey resulted in the hospital's inability to ensure the provision of quality health care in a safe environment. The condition of participation for Physical Environment was Not Met

The CEO was notified immediate jeopardy was identified on 1/12/10, at 1825 hours. The immediate jeopardy was due to the obstruction of the only emergency egress corridors for the ED, Radiology Department, Cardiac Catheterization Laboratory and a special procedures (cystoscopy)

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A 700	<p>Continued From page 89</p> <p>room and obstructed fire alarm manual pull stations in the emergency department and radiology department at Rancho Springs Medical Center, creating an increased risk for failure to protect patients, staff and visitors and an increased risk to evacuate patients through the corridors in the event of a fire or other emergency. (See K38, K52 and K72 of the Life Safety Code survey document).</p> <p>After implementation of an acceptable plan of correction, the CEO was notified the immediate jeopardy was abated on 1/19/2010 at 1530 hours.</p> <p>Findings:</p> <p>The hospital failed to ensure the hospital is protected from fire, and that all building construction, fire protection systems and egress/exist corridors are maintained as required. The results of the survey and interviews are cross referenced to the CMS 2567 representing the K tags for the Life Safety Code. (See A701 and A710 in the Health Survey and K11, K12, K25, K29, K38, K50, K51, K52, K72 and K142 of the LSC survey document)</p> <ol style="list-style-type: none"> The hospital failed to maintain the integrity of the occupancy separation walls, as evidenced by unsealed penetrations in one wall in the Wound Care Center. (See K11 of the LSC survey document) The hospital failed to maintain the integrity of the building construction, as evidenced by the failure to seal penetrations in the walls and ceilings. Penetrations in the walls in the Wound Care Center hyperbaric room would allow the 	A 700		
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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM		STREET ADDRESS-CITY STATE ZIP+4 CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562	
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A 700	<p>Continued From page 90</p> <p>spread of smoke or fire in a oxygen enriched environment (See K12 and K142 of the LSC survey document)</p> <p>3. The hospital failed to maintain hazardous areas with 1 hour rated construction and failed to ensure hazardous areas are separated from other spaces by smoke resisting partitions and self closing doors. (See K29 of the LSC survey document).</p> <p>4. The hospital failed to ensure that exit access corridors were maintained free of obstructions to allow the evacuation of patients in the event of a fire. (See K38 of the LSC survey document).</p> <p>5. The hospital failed to maintain the integrity of the smoke barrier walls, as evidenced by the failure to seal penetrations in the smoke barrier walls in the emergency department and radiology department. (See K25 of the LSC survey document).</p> <p>6. The hospital failed to ensure fire drills are held at least quarterly on each shift and staff are familiar with fire procedures. (See K50 of the LSC survey document).</p> <p>19.7.12 - Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.</p>	A 700	

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A 700	Continued From page 91	A 700		
	<p>7. The hospital failed to maintain the integrity of the fire alarm system devices in the Wound Care Center, in accordance with NFPA 99, Chapter 19, NFPA 101 and NFPA 72. (See K51 of the LSC survey document).</p> <p>8. The hospital failed to ensure maintenance of the fire alarm manual pull station devices. The devices are required to be readily available and unobstructed. This was evidenced by two manual fire alarm pull stations that were obstructed by hospital beds and equipment. (See K52 of the LSC survey document).</p> <p>9. The hospital failed to maintain the egress path in exit corridors free of all furnishings that obstruct access to or egress from exits. This was evidenced by a heat pump, a computer on wheels (COW), chairs, tables, vital machines, hospital beds, patient transport gurneys and other equipment that were placed in the exit corridors in patient treatment areas of the hospital. (See K72 of the LSC survey document).</p> <p>10. The hospital failed to maintain the integrity of the hyperbaric facility in accordance with NFPA 99, Chapter 19 and NFPA 101. This was evidenced by failing to maintain the building construction and the occupancy separation walls, by failing to ensure fire alarm notification, by failing to provide smoke detection devices in required areas, by failing to conduct fire evacuation drills, and by failing to maintain the integrity of the electrical wiring and connections. (See K142 of the LSC survey document).</p>			
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT	A 701		
	The condition of the physical plant and the overall			

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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25600 MEDICAL CENTER DRIVE MURRIETA, CA 92562
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(K5) COMPLETE DATE
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A 701 Continued From page 92 A 701

hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

This STANDARD is not met as evidenced by: Based on observation and staff interview, the hospital failed to ensure that the physical plant, equipment and hospital environment was maintained in such a manner that the safety and well-being of patients were assured. By not maintaining exit access in the emergency department (ED), by unsealed penetrations in the occupancy separation walls in the Wound Care Center, and by obstructed access to manual pull stations, the facility created the potential for lack of safety. This affected 19 patients in the ED and in the radiology department corridor outside the ED, visitors in the ED, radiology department patients, Wound Care Center patients and hospital staff. This could result in the inability to evacuate patients in the event of a fire resulting in potential harm or death.

Findings:

The hospital failed to ensure the hospital is protected from fire, and that all building construction, fire protection systems and egress corridors are maintained as required. The results of the survey and interviews are cross referenced to the CMS 2567 representing the K tags for the Life Safety Code. (See A710 of this document and K11, K12, K36, K52, and K72 of the LSC survey document).

- 1 The hospital failed to maintain the integrity of the occupancy separation walls, as evidenced by penetrations in one wall in the Wound Care Center. This could result in the spread of smoke

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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID NUMBER	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
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A-701	<p>Continued From page 93 and fire.</p> <p>2 The hospital failed to maintain the integrity of the building construction, as evidenced by the failure to seal penetrations in the walls and ceilings. Penetrations in the walls in the Wound Care Center hyperbaric room would allow the spread of smoke or fire in a oxygen enriched environment. (See K12 and K142 of the LSC survey document)</p> <p>3 The hospital failed to maintain the integrity of the smoke barrier walls, as evidenced by the failure to seal penetrations in the walls in the emergency department and radiology department (See K25 of the LSC survey document)</p> <p>4 The hospital failed to ensure that exit access corridors were maintained free of obstructions to allow the evacuation of patients in the event of a fire (See K38 of the LSC survey document).</p> <p>5 The hospital failed to ensure maintenance of the fire alarm manual pull station devices. The devices are required to be readily accessible and unobstructed. This was evidenced by two manual fire alarm pull stations that were obstructed. (See K52 of the LSC survey document)</p> <p>6 The hospital failed to maintain the exit corridors free of all furnishings that obstruct access to or egress from exits. This was evidenced by a heat pump, a computer on wheels (COW), chairs, tables, vitals machines, hospital beds, hospital gurneys and other equipment that were placed in the exit corridors in patient treatment areas of the hospital (See K72 of the</p>	A-701		
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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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A 701 Continued From page 94
LSC survey document)
A 710 482.41(b)(1)(2)(3) LIFE SAFETY FROM FIRE A 710

(1) Except as otherwise provided in this section-

(i) The hospital must meet the applicable provisions of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD, or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

(ii) Chapter 19.3.6.3.2 exception number 2 of the adopted edition of the LSC does not apply to hospitals.

(2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients.

(3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and

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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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A 710 Continued From page 96
gurneys/beds were observed in the hallways of the ED. The eight ED patient curtained areas (bays) were also full. Concurrently, M13 and E154 stated the patients in the corridors were waiting for an inpatient bed. The eight patients in the corridors had portable vital signs and cardiac monitoring machines at their bedsides. In addition, visitors were observed sitting in chairs next to the patient's gurneys. This made walking down the corridors difficult to maneuver without tripping on pieces of equipment and/or chairs. (See K36 and K72 of the LSC survey document).

A 710

2 On 1/11/10 at 1400 hours and 1/12/10 at 0950 hours, the hospital's Rancho Springs campus ED was toured and the following was observed on both days:

There was a double doorway that served as an exit from the ED into the hallway of the Radiology Department. The long radiology hallway had ED patients on gurneys lining the entire right side of the hallway all the way to the exit. A shorter hallway on the left had two patients in gurneys lining the left side which filled the left side to the exit doors. The short Radiology hallway had the numbers 11 and 12 over each respective patient gurney and each patient gurney lining the long hallway had a number on the wall over each gurney, these were numbered 13 through 18. Between each gurney there was a portable screen. In addition to the gurneys blocking egress from the hallway, there were visitors on chairs and portable equipment, for example an EKG machine, and patients being transported down the hallway during which time the hallway was completely blocked.

As noted above, the ED patient gurneys were in

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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(X5) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) DATE COMPLETE
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A 710 Continued From page 97

the Radiology hallway. Between gurneys 13 and 14 was a doorway to the CAT scan room between gurneys 14 and 15 there was a doorway into an X-ray room, between gurneys 15 and 16 there was a control room and at the end to the hallway there was a fluoroscopy room. Additionally, across from Gurney 15 there was a special procedure room. The patient activity in and out these rooms added to the crowding of the hallways.

3. On 1/11/10 at 1540 hours, M48 stated there were ED patients down the Radiology hallway 80% of the time.

4. On 1/12/10 at 1000 hours, a patient in a bed was being wheeled from the Radiology Department down the short hallway to the Medical/Surgical department. In order for the patient in the bed to get through the hallway, two visitors at the side of the Gurney #12 stood up, removed themselves and their chairs out into a hallway. As the bed passed by gurney the hallway was completely blocked.

5. A tour of the hospital was conducted during the week of 1/11/10 through 1/14/2010. On 1/12/10 it was observed that patients were being relocated from the emergency department (ED) into the hallway, extending toward ultrasound and the cardiac catheterization laboratory. These patient gurneys were noted to obscure and block access to the fire alarm pull stations. Red lines placed on the floor of the hallway, to identify the pull stations, were obscured. Interviews with nursing staff, including E15 and E16, revealed that the ED nurses were unable to identify the location of the fire alarm pull stations. (See X52 of the LSC survey document)

A 710

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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25300 MEDICAL CENTER DRIVE MURRIETA, CA 92582
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(X4) IS THIS A REPEAT SURVEY?	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(X5) FROM PAGE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) TOTAL FROM PAGE
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A 710 Continued From page 98

A / 10

6. During a tour of the Wound Care Center on 1/13/10, 1/14/10 and 1/15/10, the facility was observed and records for fire drills and fire sprinkler testing were requested:

- a. There were penetrations in the occupancy separation wall, in the Wound Care Center
- b. There were penetrations in the walls in the Wound Care Center hyperbaric room that would allow the spread of smoke or fire in a oxygen enriched environment
- c. There were no manual pull stations located in the Wound Care Center building
- d. There were no annunciation devices installed at the Wound Care Center to notify patients and staff in the event of a fire. There was no audible alarm activation during testing of the fire sprinkler system
- e. There were no records for fire drills during four of four quarters and no records for fire sprinkler quarterly testing for three of four quarters. (See K11, K12, K50, K51 and K142 of the LSC survey document)

7. A tour of the hospital was conducted during the week of 1/11/10 through 1/15/10. On 1/12/10 it was observed that patients were being relocated from the emergency department (ED) into the hallway, extending toward the ultrasound room and the cardiac catheterization laboratory. The patient gurneys were noted to obscure and block access to the fire alarm pull stations. The red lines placed on the floor of the hallway to identify the pull stations, were obscured. Interviews with the nursing staff, including E15 and E16, revealed that the ED nurses were unable to identify the location of the fire alarm pull stations.

8. On 1/11/10 at 1400 hours and 1/12/10 at 0950 hours, the hospital's RSMC campus ED was toured and the following was observed on both

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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS CITY STATE ZIP CODE 75500 MEDICAL CENTER DRIVE MURRIETA, CA 92562
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
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A 710 Continued From page 99
days

There was a double doorway that served as an exit from the ED into the hallway of the Radiology Department. The long radiology hallway had six ED patients on gurneys lining the entire right side of the hallway to the exit doors. A shorter hallway on the left side had two ED patients in gurneys which filled half of the hallway to the exit doors. The gurneys along the hallway were identified by their respective numbers written on the wall from 11-16. Between each gurney was a portable screen. In addition to the gurneys blocking egress from the hallway, there were visitors on chairs and portable equipment, e.g., an EKG machine. These gurneys and medical equipment, aside from the visitors, were noted to block the way of patients being transported down the hallway.

Moreover, the patient activity of going in and out of Radiology rooms added burden to the already crowded traffic of the Radiology hallway. It was noted that between gurneys 13 and 14 was a doorway to the CAT scan room while between gurneys 14 and 15 there was a doorway into an X-ray room. There was a control room between gurneys 15 and 16 and at the end to the hallway, there were the fluoroscopy room and the cardiac catheterization laboratory. Additionally, across from Gurney 15 there was a special procedure room.

On 1/11/10 at 1540 hours, M48 stated there were ED patients down the Radiology hallway 80% of the time.

On 1/12/10 at 1000 hours, a patient in a bed was noted being wheeled from the Radiology Department down the short hallway to the

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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25800 MEDICAL CENTER DRIVE MURRIETA, CA 92562
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	LSC COMPLIANCE DATE
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A 710	Continued From page 100 Medical/Surgical department. In order for the patient in the bed to get through the hallway, two visitors at the side of the Gurney #12 stood up, removed themselves and their chairs out into another hallway. As the bed passed by the gurney, the hallway was observed almost completely blocked.	A 710		
A 724	482 41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on interviews, and observations, the hospital failed to ensure an acceptable level of patient safety by the removal of infant safety alarms from the newborn nursery. The hospital failed to ensure the performance of routine maintenance on two of two medication refrigerators located in the main pharmacy which could lead to inaccurate temperature ranges compromising drug stability and sterility. In the ICU at RSMC campus, a pacemaker had an expired battery, while the other two pacemakers and a neurological tester in the ICU at IVMC did not have current Biomedical stickers which could potentially result in equipment failure on both campuses. In addition, the anesthesia machine in the L&D suite was found without an Ambu bag and a glucometer (medical equipment to check blood sugar level) in the Post Partum unit was found dirty with blood stains. This resulted in the potential for a delay in providing life sustaining treatment, the spread of infection, an unsafe environment for neonates and unusable medications.	A 724		

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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA, 92562
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) ID PREFIX TAG
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A 724 Continued From page 101
Findings

A 724

1. A tour of the hospital, conducted on 1/11/10 through 1/15/10. During the onsite tour of 1/11/10 at approximately 1300 hours, and on 1/14/10, hospital staff M46 revealed that infant safety alarms had been removed from the hallway directly outside the newborn nursery. When interviewed on 1/14/10, at approximately 1100 hours, M46, AS3, and E42 revealed that the hallway alarm directly outside the nursery entrance/exit had been removed approximately one year earlier for installation in the new hospital building. During the tour of the labor and delivery areas, including the newborn nursery, no security alarms had been provided to secure the two exit doors, directly adjacent to the newborn nursery and no mechanism was in place to provide security in the hallway in the direction of the emergency department, to secure the area to prevent infant abduction.

2. At RSMC, on 1/14/10 at 1415 hours, M30 stated that the refrigerators in the hospital that contain vaccines and other medications were not given routine maintenance. "All we do is a visual inspection. There is nothing written by us." M30 stated, this was the way it was documented in the Plant Operation's P&P.

On 1/14/10 at 1435 hours, M46 stated that he had not needed to inspect medication refrigerators because he had not been called. Routine maintenance was performed visually. When asked if he had documentation when this visual maintenance was done, he stated no.

On review of the policy and procedure entitled, "Routine Maintenance of PDM Equipment" last revised in 11/09, on page 6 under Maintenance of

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NAME OF PROVIDER/SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS-CITY-STATE ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562
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X4: ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE COMPLETE
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A 724	<p>Continued From page 102</p> <p>Refrigeration Units, "All patient refrigeration units shall be given a preventive maintenance and check at least annually using the following guidelines</p> <ol style="list-style-type: none"> 1. Clean condenser coils and compressor areas 2. Check for loose screws and nuts. 3. Check operation of condenser and evaporator fans for noise or other signs of malfunction 4. Check evaporator drain for proper drainage 5. All discrepancies shall be entered on work orders." <p>3 a. On 1/11/10 at 1000 hours, an inspection of the ICU at RSMC showed the battery in the internal pacemaker was expired. This was acknowledged by M50 who was present.</p> <p>b. On 1/13/10 at 1130 hours, an inspection of the ICU supply room at IVMC showed one internal pacemaker with the serial number PFG021434P with no Biomedical sticker and another internal pacemaker with the serial number PEP021015P with a Biomedical sticker dated 10/08. Additionally, there was a handheld device labeled as a Stratavarus Serial #10374 (a neurological testing unit) that had no Biomedical sticker. The batteries in this unit were undated.</p> <p>During an interview with M33 on 1/13/10 at 1140 hours, he stated he was unaware of the Stratavarus unit. He stated the recent Biomedical checks for the pacemaker units were on a handheld device which he was unable to access during the interview.</p> <p>On 1/14/10 a record for each of the pacemakers titled "Masterplan i Desk" was provided to the surveyor which showed the two pacemakers with</p>	A 724		
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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 724 Continued From page 103
the following comments for both pacemakers
"01/14/2010CVH-Facility had PMs scheduled annually for this device. Should be semi-annual. Change made this date"

4. During a tour of the Labor and Delivery Room across from the Nursery at RSMC, conducted on 1/11/10 at 1000 hours with E45 and M54, the anesthesia machine inspected was without an Ambu bag, a necessary equipment needed for resuscitation and to support patients' respiratory depression. E45 had to step out of the room to provide the necessary equipment.

5. During a tour of the Post Partum unit at RSMC conducted on 1/11/10 at 1100 hours with E45 and M54, a glucometer was found dirty with blood stains.

E45 demonstrated how the quality control was done but admitted to not being sure if there was a hospital P&P regarding glucometer cleaning and maintenance.

A 724

A 747 482.42 INFECTION CONTROL

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

This CONDITION is not met as evidenced by Based on observation, interview, and document review, the hospital failed to provide a sanitary environment to avoid sources and transmission of infections and communicable diseases as evidenced by

A 747

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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 01/19/2010
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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS CITY STATE ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562
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.X4) (C) 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
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A 747	Continued From page 104	A 747	
	1. Failure to develop and implement a policy and procedures that ensured all healthcare workers were screened for tuberculosis (See A749, #1)		
	2. Failure to implement hospital policy and procedures ensuring surgical attire was implemented in all areas where surgical procedures were performed (See A749, #2).		
	3. Failure to implement hospital policy and procedures for the use of Cidex OPA, ensuring that individuals who used the high level disinfectant had training on the safe use, appropriate disposal, and that the high level disinfectant was used in a well ventilated environment (See A749, #3),		
	4. Failure to implement hospital policy and procedures for standard based precautions (See A749, #4)		
	5. Failure to develop and implement a policy and procedure that ensured single patient use items were not used for multiple patients (See A749, #5),		
	6. Failure to develop and implement a policy and procedure that ensured that the inside of hyperbaric chambers were routinely disinfected (See A749, #6).		
	7. Failure to ensure implementation of the P&P for labelling and changing intravenous solutions. (See A749 #7).		
	8. Failure to ensure the correct use of PPE (See 749 #8 and #10)		
	9. Failure to develop and implement a policy and		

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PRINTED: 04/13/2010
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	INCUMPLIANCE CORRECTION A. BUILDING _____ B. WING _____		(X2) DATE SURVEY COMPLETED 01/19/2010
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)		DATE COMPLETION (MM/DD)
A 747	Continued From page 105 procedure that ensured potentially hazardous foods were thoroughly cleaned reducing the risk of cross contamination (See A749 #9) 10. Failure to implement hospital policy on dish and silverware cleaning and sanitizing procedures to prevent cross contamination (See A749, #11) The cumulative effect of these systemic problems resulted in the failure by the hospital to provide quality care in a sanitary environment	A 747			
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 observation, interview, and document review, the infection control officer failed to develop and implement policies and procedures governing control of infections and communicable diseases. This resulted in incorrectly cleaned sterile instruments, contamination of water systems, staff exposure to noxious chemicals, equipment used that could not be properly cleaned, prolonged use of IV solutions and medications and incorrect isolation, food sanitation and PPE procedures and the potential for tuberculosis and infectious disease exposure, surgical infections and food borne illness Findings: 1. On 1/14/10 at 1225 hours, an interview was conducted with the M56. M56 was asked for a list	A 749			

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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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L41 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)	DATE COMPLETED
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A 749

Continued From page 106

A 749

of active medical staff members and mid-level practitioners (PAs), and the dates they had been screened for tuberculosis (TB)

During a concurrent interview, M56 stated that the hospital only screened employees for TB. M56 also stated that members of the medical staff and mid-level practitioners were not employees and the hospital did not require them to be screened for TB.

M56 was asked for an approximate number of active medical staff members and mid-level practitioners at the hospital. M56 stated between the two hospital campuses there were about 290 active medical staff members and 20 mid-level practitioners. M56 was asked if she was aware that in 2005, the CDC (Centers for Disease Control and Prevention) recommended that physicians and mid-level practitioners be included in the hospital's TB screening plan. M56 stated she was not aware the CDC had recommended that physicians and mid-level practitioners should be included in the hospital's TB screening program.

On 1/14/10 at 1300 hours, the 403 hospital's policy and procedure titled, "Employee physical TB annual screening" was reviewed. On page one, under the policy section, item "C" direction was given that, "All employees and volunteers with a negative or doubtful skin test will have a tuberculin PPD skin test done annually."

On 1/14/10 at 1330 hours, the CDC's 2005, Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings was reviewed. On page three of the document the CDC recommends that healthcare

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IPF: PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	INDICATE MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	ISSUE DATE QUARTER COMPLETED 01/19/2010
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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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ICD-10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ICD-10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION MUST BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
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A 749 Continued From page 107

A 749

workers (HCW) "Refers to all paid and unpaid persons working in a health care settings who have the potential for exposure to M. tuberculosis through air space shared with persons with infectious TB disease. Part-time, temporary, contract, and full-time HCWs should be included in TB screening programs. All HCWs who have duties that involve face to face contact with patients suspected or confirmed TB disease (including transport staff) should be included in a TB screening program. " A review of CDC's list of HCWs who should be included in TB screening programs included. "Physicians (assistant, attending, fellow, resident) or intern), including anesthesiologists, pathologists, psychiatrists, psychologists."

2. On 1/12/10 at 1100 hours, the RSMC Cardiac Catheterization Laboratory was toured. Prior to entering, M57 was asked at what point would the surveyor be required to change into surgical attire. M57 replied that surgical attire was not required before entering the Cardiac Catheterization Lab. During the tour, M57 was asked if permanent cardiac pacemakers were implanted in the Cardiac Catheterization Lab. M57 replied yes, permanent pacemakers were implanted.

During a concurrent interview M57 was asked for clarification on allowing street clothes in a surgical suite. M57 stated that surgical scrubs were not needed in the Cath Lab, because every morning housekeeping cleaned the Cardiac Catheterization Lab. During the interview, M57 was asked about the location and process for performing a surgical scrub. M57 stated that the surgical scrub was performed at the sink located in procedure room (approximately two feet from the procedure

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		OR: PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	N/A: MULTIPLE CONSTRUCTION A: BUILDING _____ B: WING _____		N/A: DATE SURVEY COMPLETED 01/19/2010
NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM			STREET ADDRESS CITY STATE ZIP CODE 25800 MEDICAL CENTER DRIVE MURRIETA, CA 92562		
CLIA 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)	N/A: CORRECTIVE TAG	
A 749	Continued From page 109 removed from the Ultrizyme rinsed again dried, and then wrapped in peel pouches for sterilization. E22 stated that the wrapped instruments were then sent to central supply for sterilization. E22 was asked to describe the process used to discard the Cidex OPA and Ultrizyme. E22 stated that the two solutions were discarded down the sink drain. When asked if anything was added to either solution before being discarded, E22 replied, "I just pour them down the sink drain." When asked how long she had worked in the wound center, E22 stated that she had worked in the wound center for two and a half years. When asked who had trained her on the process used to clean and sanitize the instruments, E22 stated she was trained by the previous manager of the wound center. On 1/12/10 at 1600 hours, the hospital's 11/10/09 policy and procedure titled "High level disinfection with Cidex OPA" was reviewed. On page one, under additional information, item 8, the direction was: "Only the following approved locations are allowed to high-level disinfect equipment: Rancho Springs - SPD (sterile processing department), and Imaging Inland Valley / Outpatient Imaging Center - Cardiology Department and Radiology - Ultra sound probes On page 2, under additional information, staff were directed to use Cidex OPA in a well ventilated area and in closed containers with tight fitting lids. If adequate ventilation was not provided by the existing air conditioning system.	A 749			

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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)
A 749	<p>Continued From page 110</p> <p>use local exhaust hoods, or in ductless fume hoods/ portable ventilation devices, which contain filler media, which absorb ortho-Phthalaldehyde from the air.</p> <p>On page 4, under directions for discarding solution, staff was directed to pour one container of Kem-Safe neutralizing powder into one gallon container of Cidex OPA, stir solution, reaction is complete in five minutes, and a color change will occur, the neutralized solution is safe for disposal via hopper</p> <p>On 1/13/10 at 0800 hours a request was made to review the air exchange reports for the wound center and the manufacturers' recommendations for both the Cidex OPA and Ullizyme.</p> <p>During an interview on 1/13/10 at 0830 hours, M14 stated that the hospital conducted environment of care (EOC), rounds twice a year, and the EOC staff was not aware that Cidex OPA was used in the wound center. M14 also stated that the hospital had no documentation showing that the air exchanges had been monitored in the wound care center's soiled utility room.</p> <p>On 1/13/10 at 1000 hours, the 2009, Association of periOperative Registered Nurses (AORN), Standards and Recommended Practices was reviewed. On page 421, Under the section titled, "Recommended HVAC (Heating, Ventilation and Air Conditioning), Settings" disclosed that AIA (American Institute of Architects) recommended that soiled decontamination rooms have a minimum of 10 air exchanges per hour, and that the air should not be recirculated</p> <p>On 1/13/10 at 1100 hours, the manufacturer</p>	A 749	

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A 749	<p>Continued From page 111</p> <p>recommendations for Cidex OPA and were provided, reviewed and disclosed:</p> <p>a. The manufacturer of Cidex OPA labeled the solution as "A high level disinfectant for reprocessing heat sensitive reusable semi-critical medical devices, for which sterilization is not feasible, and when used according to the directions for use." Under directions for use the manufacturer directed that the solution did not require activation before use, and that the solution was to be used, as provided for a period up to 14 days (with use of test strips before each use). The manufacturer also directed that 25 grams of glycine (free base) should be used to neutralize one gallon of Cidex OPA (minimum recommended neutralization time is one hour), before discarding residual solution into a drain.</p> <p>b. The manufacturer of Ultrazyme labeled the solution as a multi-enzyme detergent, and directed that one ounce of product was to be added to one gallon of water. The manufacturer also directed that after removal, the instruments were to dry before proceeding to the disinfection process.</p> <p>4. On 1/11/10 at 1000 hours, a tour was conducted of the medical surgical unit of the RSMC campus. During the tour E26 was asked to explain the process used to identify inpatients in transmission based infection control precautions. E26 stated that nursing staff entered those specific patients into the computer system, and each morning she printed the patient list. E26 stated that she then made rounds to ensure that the appropriate transmission based precautions had been implemented, and were appropriate for each patient.</p>	A 749	

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A 749 Continued From page 112

A 749

During the tour, on 1/11/10 at 1030 hours, a sign posted outside Patient 13's room showed that the patient was in "Protective precautions." A review of the patient census printed on 1/11/10 at 0812 hours, documented that Patient 13 was in, "Protective precautions."

A review of E26's "Isolation log" dated 1/11/10 and printed at 1011 hours, showed that Patient 13 was not included in the list of patients in transmission based precautions.

On 1/11/10 at 1040 hours, Patient 13's medical record was reviewed. Documentation showed that the patient was admitted on 1/8/10, with diagnoses that included bone marrow suppression.

A review of the physicians' orders disclosed an order written 1/10/10, directing that the patient was, "Okay to walk in hall with mask ad lib." A review of the nursing flow sheets showed beginning on 1/9/10, nursing documented that the patient was in, "Neutropenic precautions."

During a concurrent interview, E26 was asked how nursing staff would know what protective precautions meant. E26 stated that nursing staff would just know.

On 1/11/10 at 1130 hours, the hospital's 5/09 policy and procedure titled "Isolation precautions" was reviewed. On page one of the policy, under the purpose section, the policy directed that, "reverse (or protective) isolation - there is no CDC category for reverse (protective) isolation. Strict adherence to standard precautions is all that is necessary."

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A 749 Continued From page 113

A 749

5. On 1/12/10 at 1450 hours, a tour of the IVMC intensive care unit (ICU) was conducted. During the tour, a request was made to inspect the pressure infusers used at the hospital. M13 escorted the surveyor to the equipment storage room. The surveyor was shown two pressure infusers manufactured by different companies. Stamped on the outside of the first pressure infuser was, "Recommended for single patient use." The plastic package covering the second pressure infuser documented, "Disposable pressure infuser."

During a concurrent interview, M13 stated that she was not aware that the pressure infusers were recommended for single patient use. M13 was also asked to clarify with the manufacturer what "Disposable pressure infuser" stamped on the outside of the second pressure infuser's package meant.

On 1/13/10 at 0800 hours, the hospital provided documentation from the manufacturer of the second pressure infuser showing the pressure infuser was a single patient use item.

6. On 1/12/10 at 1344 hours, a tour was conducted of the wound care center including the room where the two hyperbaric chambers were located.

During a concurrent interview, E21 was asked to explain the process used to clean the hyperbaric chambers. E21 stated that the inside of the two hyperbaric chambers were cleaned once a week. When asked to identify the cleaning solution E21 stated that staff used soap and water to clean the inside of the hyperbaric chamber. E21 also

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LINE # PROBID TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	AL PROBID TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	CORRECTIVE ACTION DATE
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A 749 Continued From page 114 A 749

stated that he followed the manufacturer recommendations listed in the user manual.

On 1/12/10 at 1500 hours, the manufacturer's user guide was reviewed. The manufacturer's guide directed that the outside of the hyperbaric chamber was to be wiped down with a lint free cloth using a mild non-abrasive soap. The manufacturer recommended that the inside of the acrylic hyperbaric chamber be cleaned and disinfected in accordance with approved medical staff policies using one of the 10 approved products. The manufacturer's user guide did not specify how frequent the inside of the hyperbaric chamber should be cleaned.

On 1/12/10 at 1630 hours the wound care center's policy and procedure was reviewed. The wound care center's policy and procedure contained no additional information directing wound care staff on how frequently the inside of the acrylic hyperbaric chamber should be cleaned.

7. Review of the hospital P&P for the IVMC and RSMC campuses entitled IV Certification and Administration For Licensed Nurses, revision date 11/07, showed that all peripheral IVs would be labeled with the date and initials of the nurse initiating the IV. Further review of the policy also showed that all IV solutions would be changed every 48 hours, if they did not contain additives. IV solutions containing additives would be changed every 24 hours, if prepared by appropriate hospital staff. Manufactured pre-mixed IV solutions would be changed equal to or less than every 48 hours.

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ID# OR PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IF PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IF COMPLETE DATE
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A 749 Continued From page 115 A 749

On 1/12/10 at 1000 hours, during a tour of the 7 West medical/surgical unit at the IVMC campus with M29, it was found that IV medication bags in rooms 251, 253, 259, and 252 did not have labels to show the date, time, and signature to show when the IV medication bags were hung. When M29 was asked why some IV medication bags were labeled with date, time, and signature of person hanging the IV and others were not, she was not able to answer and deferred the question to E32. E32 stated that IV bags were usually labeled when hung.

On 1/12/10 at 1100 hours, during a tour of the 7 Central medical/surgical unit at the IVMC campus with E30, IV bags were found unlabeled in rooms 235 and 221.

On 1/12/10 at 1200 hours, during a tour of the 2 East medical/surgical unit at the IVMC campus with M30, IV bags in rooms 205, 206, 207, and 208 were not labeled. When M30 was asked about the unlabeled IV bags, he stated that he was not sure what the usual practice was and believed the nurses usually documented in the MAR the time and date of when IV bags were hung. M30 added that he would find out what the practice was.

On 1/12/10 at 1245 hours, during an interview with E6, she stated that the normal practice was to document on the MAR of when IV's were hung. This was not in accordance with hospital P&Ps.

8. Review of the P&P titled "Personal Protective Equipment" (PPE) showed gloves should be removed first before removing the cover gown, used for isolation precautions.

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44-74 PREP # 149	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IC PREP # 186	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IC PREP # 186
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A 749 Continued From page 116

A 749

On 1/11/10 at 1012 hours at the RSMC's ICU M50 was observed removing PPE in a contact isolation patient's room. M50 untied and removed the protective gown with the soiled gloves on.

9. On 1/11/10 at 0900 hours on the RSMC campus, E14 was observed with one cantaloupe in a bowl of water in a food preparation sink. E14 stated that she rinsed the cantaloupe in running water and then peeled the melon for service to patients.

Interview with E31, responsible for the Food and Dietetic Department, stated there was no policy that specified the thorough cleaning of cantaloupe or leaving produce in standing water. The FDA Food Code dated 2005 identifies cantaloupe as a potentially hazardous food that requires thorough cleaning of the rough and netted exterior to prevent the potential of food borne illness. The Food Code specifies ready-to-eat fruits not be in standing water where cross contamination can occur.

On 1/12/10 at 0950 hours two infection control staff were interviewed. M14 stated he was responsible for the hospital wide infection control program.

M14 and E26 stated the infection control monitoring was part of the environmental rounds and emphasis was on cleanliness of the environment, concentration of solutions, cleaning schedules, and equipment temperatures when reviewing the kitchens.

M14 stated that he was not familiar with the food

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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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(X5) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) N/A (X7) (X8)
A 749	<p>Continued From page 117</p> <p>safety procedures like HACCP (hazard analysis and critical control point) program developed in the FDA Food Code. He stated that he had not reviewed the policies with the dietary management staff for food safety practices to prevent cross contamination and food borne illness. M14 stated he had not reviewed the practices of ensuring the cantaloupe were in compliance with the FDA Food Code standards for thorough cleaning.</p> <p>10. On 1/14/10 at 1200 hours at the IVMC campus kitchen, E52 was observed putting clean disposable plastic gloves in her apron pocket and then washing hands. E52 then put on the contaminated disposable gloves from her apron pocket. E52 stated that she got the gloves and put them in her pocket before washing her hands to save time. E31 acknowledged the dietary staff should put on disposable gloves after washing hands and not put them in the apron pockets.</p> <p>11. On 1/13/10 at 1030 hours at the IVMC campus kitchen, E102 was observed using a cloth to wipe the sanitized patient trays at the end of the dishwashing cycle. E102 stated the trays were wet on the back and she used the cloth daily to dry the remaining moisture.</p> <p>Review of the policy titled Dishes and Silverware Cleaning and Sanitizing Procedures on 1/13/10 at 1600 hours showed "Air-dry all utensils."</p> <p>E31 acknowledged the trays were to be air-dried and not dried with a cloth to prevent cross contamination.</p>	A 749		
A 800	482.43(a) CRITERIA FOR DISCHARGE EVALUATIONS	A 800		

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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 01/19/2010
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 800	<p>Continued From page 118</p> <p>The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and medical record review, the IVMC and RSMC campus, both failed to ensure four of 11 patients reviewed for discharge planning (Patients 42, 123, 169, and 319) were assessed early during hospitalization for discharge planning needs. This had the potential to increase the chances for the patients to suffer from further illness or injury after being discharged to home.</p> <p>Findings:</p> <p>1. On 1/12/10 at 1100 hours, during an interview with Patient 123, she stated that she was being discharged to home today and requested to speak to a CM and had not spoken to one as of yet. She stated that she lived alone and needed help so she would not cause injury to her arm anymore.</p> <p>On 1/12/10 at 1530 hours, during an observation and follow-up interview with Patient 123 and interview with E162, Patient 123 was able to ambulate without assistive devices, but was not able to stand fully erected. The upper portion of the patient's body was bent forward when she walked, which increased the patient's susceptibility for falls. Patient 123 stated that she was limited in doing some things, such as not being able to drive because of current episodes of pain in her arm. The patient also stated the physician wanted her to get unspecified subsequent services, but she did not have money</p>	A 800	

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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 26500 MEDICAL CENTER DRIVE MURRIETA, CA 92562	
LAC ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IC PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)
A 800	Continued From page 119 to pay for those services. The patient had a cast that extended from the middle of her left forearm to her hand. She also stated that she only needed temporary help. E 165 stated that a SW (social worker) came by between 1200 and 1500 hours and spoke with the patient. On 1/13/10 at 1120 hours, during an interview and medical record review with E29, she stated that each hospital was assigned four to six CM and that on Saturdays there was a CM (case manager) on duty from 0700 hours to 1700 hours. After 1700 hours the House Supervisor would be notified if there were any case management needs identified. On Sunday there was usually a CM on call, who would be notified by the House Supervisor in the event that CM needs were identified. She also stated that discharge planning was usually done within the next business day. When Patient 123's discharge planning record was presented to E29, she stated that discharge planning done for Patient 123 on the day the patient was being discharged was not the usual practice. Review of the hospital's P&P entitled, Case Management- Discharge Planning-Screening and Assessment, revision date 11/09, showed that patients were initially screened for discharge planning each morning by Case Management. In addition, it showed that CMs would identify final plans/disposition of the patient, and document patient and family agreement to discharge plans. Review of Patient 123's medical record showed the patient had been admitted on 1/10/10. The History and Physical Examination showed the patient was alert and oriented, suffered a left wrist fracture, and the patient lived alone. Review of	A 800	

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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 800

Continued From page 120

the discharge planning record, showed the Initial Discharge Planning Screening was not done until 1/11/10. The Needs Assessment portion of the discharge planning record was not done until 1/12/10, which was the day of the patient being discharged from the hospital. SW discharge assistance was ordered by the physician on 1/12/10. Further review of the record also showed discharge instructions, dated 1/12/10, that showed the box for driving restrictions was not checked, and the community resource information and additional home care instruction portions of the document were left blank. There was no documentation to show that a CM or SW had spoken to the patient in regards to discharge planning.

Review of the CM schedule for the month of January 2010 showed that there was a CM on-call on 1/10/10 (Sunday), and that seven CMs and one SW were on duty on 1/11/10.

2. On 1/12/10 at 1220 hours, Patient 169 and family were interviewed regarding his discharge plan. Patient 169 stated he was readmitted to the hospital on 1/3/10 for a complication that developed after his last surgical procedure. The patient and family had not received any information regarding a discharge plan at the time of the interview. The family did not recall that there was any discharge planning explained to them for the prior admission. No discharge instructions had been provided for either admission. See A395.

3. On 1/11/10 at 0900 hours, during interview with Patient 42 and the patient's family member, they stated that they were never approached by a SW or CM regarding discharge planning. The patient

A 800

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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 800	Continued From page 121 was due to be discharged that day. During that time, the patient was observed sitting at the bedside with a walker placed in front of her. On 1/11/10 at 1000 hours, review of Patient 42's medical record with E34 showed the patient was admitted on 1/9/10 (Saturday). Review of the Admission Data Base dated 1/9/10, showed the patient was identified for discharge planning needs and a referral was made to the case management department on the day of admission. No discharge planning record was found at the time of the medical record review. E34 concurred the referral to case management was done, but the discharge planning was not. On 1/11/10 at 1200 hours, the surveyor was given Patient 42's discharge planning document. The document showed the initial discharge screening and needs assessment was done on 1/11/10, on the day of the patient being discharged to home. 4. Review of Patient 319's medical record showed the patient was admitted on 12/30/09 for a hip fracture. Further review of the medical record showed documentation of the discharge planning initial screening and needs assessment was not done until 1/5/10. Review of the CM's schedule for the month of December 2009 and January 2010 showed that CMs were on duty from 12/30/09 to 1/4/10. The discharge planning P&P had not been followed for Patient 319.	A 800			
A 806	482.43(b)(1) DISCHARGE PLANNING NEEDS ASSESSMENT The hospital must provide a discharge planning evaluation to the patients identified in paragraph	A 806			

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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 28500 MEDICAL CENTER DRIVE MURRIETA, CA 92562
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(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID NUMBER TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLIANCE DATE
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A 808

Continued From page 123

A 808

The patient and family were interviewed regarding his discharge plan. Patient 169 stated he was readmitted to the hospital on 1/3/10 for a complication that developed after his last surgical procedure. The patient and family had not received any information regarding a discharge plan at the time of this interview. The family recalled from a previous admission that Patient 169 had emergency surgery that resulted in an extensive procedure due to complications. The family did not recall that there was any discharge planning explained to them for that admission. The family stated that at that time, there was one conversation with a physical therapist about stairs in the home. No other discharge instructions had been provided for either admission.

a. On 1/14/10, review of Patient 169's medical record showed an Admission form, dated 12/28/09, that Patient 169 was admitted on 12/28/09. A note on this section instructed that if any risk factors were identified, to initiate a referral to Case Management (CM). A referral to CM was made on 12/29/09. Further review of the medical record showed E51 did a discharge planning assessment on 12/29/09. The only risk factor identified was for no insurance. The rest of the sections on the form were left blank. There was no further assessment of discharge needs by E51.

b. Further review of the patient's medical record showed Patient 169 was readmitted on 1/3/10 for pain and vomiting. On 1/14/10, a review of the Admission Data Base used for the patient's readmission showed the section for determining if a CM referral was needed was not completed. The patient had been identified on the section for not having medical insurance, which was

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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 808 Continued From page 124 A 808

considered a risk factor. Once a risk factor was identified on section of the document, the case management department was to be contacted to conduct a more indept discharge planning evaluation. Review of the Discharge Planning Extended Screen Data, completed by E 159, also identified Patients 169's readmission as a risk factor

On 1/14/10 at 1400 hours, during an interview, E158 stated she readmitted Patient 169 on 1/3/10. E158 stated the admitting nurse should have initiated the discharge care plan on admission. E158 reviewed the patient's record and stated the discharge care plan had not been initiated. A concurrent interview with M30, disclosed Patient 169 had insurance. The Admission Data Base that identified Patient 169 of not having medical insurance was incorrect while the appropriate risk factor, the patient's readmission, was left blank.

2. On 1/12/10 at 1100 hours, Patient 123 expressed that she would be needing assistance once discharged from the hospital. She was to be discharged on 1/12/10. There was no documentation in her medical record that addressed post hospital needs. See A800 #1.

3. On 1/12/09, review of Patient 184's medical record showed the patient had been admitted 1/9/10 for chest pain. The discharge planning initial screening was done on 1/11/10, however; the needs assessment and therefore an evaluation of post hospital needs were not addressed.

On 1/13/10 at 1120 hours, during an interview with E29, she stated that discharge planning was

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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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ID# (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)	DATE COMPLETE (MM/YY)
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A 808 Continued From page 125 usually done within the next business day A 808

A 809 482 43(b)(4) SELF CARE PATIENT EVALUATION A 809

The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

This STANDARD is not met as evidenced by: Based on observation, interview, and medical record review, IVMC hospital failed to ensure discharge planning addressed post hospital needs for three of 11 sampled patients (Patients 123, 169 and 184). This had the potential for patients to be not cared for once discharged back into previous environment prior to hospitalization.

Findings

The hospital failed to ensure the discharge planning evaluation for Patients 123, 169 and 184 determined their capacity for self care and/or the need for assistance. See A808.

A 810 482 43(b)(5) TIMELY DISCHARGE PLANNING EVALUATIONS A 810

The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

This STANDARD is not met as evidenced by: Based on interview and medical record and hospital record review for IVMC and RSMC, both campus failed to ensure discharge planning was timely implemented for four of 11 sampled.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	XII PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	XIII MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	XIV DATE SURVEY COMPLETED 01/19/2010
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XVI 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)	DATE
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A 811 Continued From page 127

A 811

stated that at that time there was one conversation with a physical therapist about stairs in the home. No discharge instructions had been provided for the previous admission. The patient and family had not received any information regarding discharge planning since being readmitted on 1/3/10.

1a. On 1/14/10, review of Patient 169's medical record showed an Admission form, dated 12/28/09, that Patient 169 was admitted on 12/28/09. A note on this section instructed that if any risk factors were identified, to initiate a referral to Case Management (CM). A referral to CM was made on 12/29/09. Further review of the medical record showed E51 did a discharge planning assessment on 12/29/09. The only risk factor identified was for no insurance. The rest of the sections on the form were left blank. There was no further assessment of discharge needs by E51.

1b. Further review of the patient's medical record showed Patient 169 was readmitted on 1/3/10 for pain and vomiting. On 1/14/10, a review of the Admission Data Base used for the patient's readmission showed the section for determining if a CM referral was needed was not completed. The patient had been identified on the section for not having medical insurance, which was considered a risk factor. Once a risk factor was identified on a section of the document, the case management department was to be contacted to conduct a more indepth discharge planning evaluation. Review of the Discharge Planning Extended Screen Data, completed by E159, also identified Patient 169's readmission as a risk factor.

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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	
(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 811	Continued From page 128 On 1/14/10 at 1400 hours, during an interview, E158 stated she readmitted Patient 169 on 1/3/10. E158 stated the admitting nurse should have initiated the discharge care plan on admission. E158 reviewed the patient's record and stated the discharge care plan had not been initiated. 2. The hospital failed to show within Patient 123's medical record a discharge plan evaluation and record of discussion with the patient regarding discharge needs. See A800 #1 3. The hospital failed to show within Patient 184's medical record a discharge plan evaluation and record of discussion with the patient regarding discharge needs. See A808 #2.	A 811		
A 822	482.43(c)(5) PREPARATION FOR DISCHARGE As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care. This STANDARD is not met as evidenced by Based on observation, interview, and medical record review, IVMC failed to ensure one of 11 patients sampled for discharge planning (Patient 123) received consultation for meeting post discharge needs. This had the potential for the patient to be discharged without any information to assist in meeting discharge needs. Findings: The hospital failed to provide discharge consultation when requested by Patient 123. See A800 #1	A 822		
A 951	482.51(b) OPERATING ROOM POLICIES	A 951		

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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 MEDICAL CENTER DRIVE MURRIETA, CA 92582		
(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) CORRECTED DATE
A 951	<p>Continued From page 129</p> <p>Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to ensure surgical equipment was safe for patient use. The failure could potentially cause serious patient injury, unnecessary delay of surgery, and prolonged anesthesia.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. At RSMC, on 1/11/10 at 1135 hours, the surgical service area was toured. In Operating Room #3, an OR table was observed placed in its lowest position. The metal cover of the base of the OR table was not completely attached to the telescoping mechanism used to raise the OR table. When E159 elevated the OR table up to its highest position, the metal cover attached to the base snapped off. Each portion of the telescoping mechanism malfunctioned and the inside contents, such as electrical cords and machine parts, were exposed. A concurrent interview with E159 revealed OR staff put an anti-embolic pump under the OR table during surgery. The staff lowered the OR table without removing the pump and the table was blocked from moving to the lowest position. M22 stated that she would notify biomedical engineering for immediate repairs. 2. A tour of the surgical suites at RSMC campus was performed on 1/11/10 at approximately 1300 hours. The temperature and humidity for each surgical suite was provided by a hand held device fixed to the wall of the surgical area. This device, 	A 951		

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A 951	Continued From page 130 or fluke as it was called by representatives from the operating room and plant maintenance, registered the room temperature and humidity. Hospital employees E141 and M46 stated that these devices had been calibrated at the factory. When asked if these devices had been re-calibrated or re-tested to ensure accuracy, representatives from the facility were unable to produce documented evidence. A review of the "Masterplan Medical Equipment Maintenance Priority Table" and "Masterplan - Medical Equipment Management Program: PM Procedures," revision date 3/08 failed to reveal evidence the flukes were included in the preventative maintenance program. The 2008 edition of Perioperative Standards and Recommended Practices by the Association of periOperative Registered Nurses states at V.b.2 and V.c that humidity and temperature of the perioperative environment should be monitored and recorded daily using a log format or documentation provided by the HVAC system.	A 951		
A1005	482.52(b)(3) OUTPATIENT POST-ANESTHESIA EVALUATION [The policies must ensure that the following are provided for each patient:] A post-anesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, no later than 48 hours after surgery or a procedure requiring anesthesia services. The post-anesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures, which have been approved by the medical staff and which reflect current standards of anesthesia care.	A1005		

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A1005	Continued From page 131	A1005		
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This STANDARD is not met as evidenced by:
Based on a review of six anesthesia open and closed medical records, the hospital failed to provide documentation that was accurate and specific to the type of anesthesia services being provided for five of six records reviewed (Patients 87, 97, 98, 300, and 310). This resulted in information specific to recovery from the type of anesthesia being utilized during the surgical procedure to not be available for clinical care of the patient.

Findings:

1. Patient 97 came to the hospital on 1/11/10 for an urgent caesarean section (c-section). The surgical procedure was completed at 0130 hours using spinal anesthesia. The post-anesthesia record was labeled as "Post-Labor Epidural Evaluation" when Patient 97 had the procedure performed under spinal anesthesia. The record for "Post-Labor Epidural Evaluation" was dated, timed and signed by MD E133; however, there was no documentation that the assessment for "movement and sensation in the lower extremities" had been evaluated.
2. Patient 98 came to the hospital on 1/10/10 for a primary c-section that was completed at 1100 hours using spinal anesthesia. The post-anesthesia record was labeled as "Post-Labor Epidural Evaluation" when Patient 98 had the procedure performed under spinal anesthesia.
3. Patient 300 came to the hospital for a repeat C-section that was performed on 1/12/10. The medical record for Patient 300 revealed that the

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A1005	Continued From page 132 post-anesthesia record was labeled as "Post-Labor Epidural Evaluation" when Patient 300 had the procedure performed under spinal anesthesia. 4. Patient 87 came to the hospital for surgical services that was performed on 1/10/10. The medical record for Patient 87 revealed that the post-anesthesia record was labeled as "Post-Labor Epidural Evaluation" when Patient 87 had the procedure performed under spinal anesthesia. 5. Patient 310 came to the hospital for surgical services provided on 1/10/10. The medical record for Patient 310 revealed that the post-anesthesia record was labeled as "Post-Labor Epidural Evaluation" when Patient 310 had the procedure performed under spinal anesthesia.	A1005	
A1100	482.55 EMERGENCY SERVICES The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the hospital failed to ensure: 1 The provision of a valid back up specialty on call schedule - See A1102. 2 ED policies were implemented by: a. Housing patients and equipment in emergency egress corridors and in front of emergency pull stations which subjected the patients to danger	A1100	

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A1102 Continued From page 134 A1102

department, a daily on call back-up physician by specialty schedule was requested. M49 produced a schedule that failed to list the name of the physician responsible for the hospitalist back-up on-call for patients requiring hospitalization. M49 stated that the hospitalist was located by computer website for the hospital intranet. However, M49 agreed that she would have difficulty contacting the physician responsible for the call in the event of computer malfunction.

A1104 482.55(a)(3) EMERGENCY SERVICES POLICIES A1104

[If emergency services are provided at the hospital --]

(3) The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the hospital failed to ensure ED policies were implemented by 1. Housing patients and equipment in emergency egress corridors and in front of emergency pull stations which subjected the patients to danger from fire for 8 ED patients and all patients in Radiology and the special procedures room; 2. Failing to have a process in place to accurately document patients arrival times in the ED which resulted in a delay in service for one of 12 sampled ED patients (Patient 16) and inaccurate/incomplete data for five of 12 sampled patients ED patients (Patients 16, 294, 295, 296, and 318); 3. Failing to provide for patient privacy. 4. Failing to have clear assignments by acuties for three of three LVNs which could potentially have an effect on the

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A1104 Continued From page 135
quality of the patient care (E10, E163, and E164).

A1104

Findings:

1. Review of the hospital's ED policy "Structure Standards: Emergency Department" showed the hospital had a commitment to a safe environment of care.

On 1/11/10 at 1400 hours and 1/12/10 at 0950 hours, the hospital's RSMC campus ED was toured and the following was observed on both days:

Egress from the Radiology hallway was blocked with eight ED gurneys with patients, equipment and visitors preventing safe exiting from the hallway. See A710.

2. Review of the hospital's ED policy "Structure Standards: Emergency Department" showed the hospital had as an objective to treat patients in a timely manner. On 1/11/10, at 1400 hours, the "Emergency Department Patient Log" at RSMC was reviewed. The log had the name of the patient, the patient's arrival time, discharge date and disposition. According to M13, who was interviewed concurrently this represented the patients arrival to the ED. Further review of patient records showed the arrival time on the ED log was the triage time and not the actual time the patient arrived to the ED.

According to M49, interviewed on 1/12/10 at 1530 hours, upon arrival to the ED non-ambulance patients obtained a form from the admissions clerk titled "ED Demographics." The patient was to fill out this form on arrival to the ED. The top of the form had a section for date and time of arrival.

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A1104	Continued From page 136	A1104	<p>Five of the 12 patient charts reviewed for MSE showed the following:</p> <p>a. At 1015 hours on 1/11/10, Patient 16 was interviewed. He was observed to have a nasogastric tube for drainage of stomach contents. Patient 16 stated he was waiting to have emergency surgery on his abdomen. The patient and family stated he had come to the ED at approximately 2115 hours on 1/9/10 with severe abdominal pain. The patient stated it had taken two hours before he saw a nurse in the ED to evaluate the severity of his condition. During the long wait in the ED before seeing a nurse, the patient had to step outside because he was embarrassed to be seen doubled over in pain. When he did see a nurse, the family member stated the patient stated his pain was 13 on a scale of 1 to 10 with 10 being the worst pain. Review of the patient's record on 1/13/10 revealed the "ER Demographics" form did not document a time that the patient arrived at the ED. There was a hand written note on this form that said the patient was called at 2240 hours and there was no answer. The ED record revealed a nurse first saw Patient 16 at 2308 hours and he complained of a "10" pain. Interview with Patient 16 at 1600 hours on 1/12/10 revealed the surgeon had found an intestinal blockage approximately the size of a small cantaloupe.</p> <p>b. Review of the ED log for 1/11/10, showed Patient 295 arrived at 1126 hours, the triage record showed the patient as triaged at 0959 hours. The ED Demographic form sections date and time of arrival were left blank.</p> <p>c. Review of the ED log for 1/12/09 showed</p>	

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A1104	<p>Continued From page 137</p> <p>Patient 296's arrival and triage times as 0959 hours. The ED Demographic form sections date and time of arrival were left blank.</p> <p>d. Review of the ED log for 1/12/09 showed Patient 294's arrival and triage times as 1053 hours. The ED Demographic form sections date and time of arrival were left blank.</p> <p>e. On 1/14/10 at 0930 hours, review of Patient 318's medical record at the IVMC campus showed a patient triage time of 1340 hours on 1/11/10. The ED Demographic form sections date and time of arrival showed the patient arrived to the hospital on 1/11/10 at 1435. When questioned about the discrepancy M13 stated sometimes the patients put down the wrong times.</p> <p>On 1/13/10 at 1630 hours, M48 confirmed the ED log did not contain the arrival patient's arrival time and there was no ongoing record that accurately showed the total time a patient was in the ED.</p> <p>3. On 1/11/10 at 1400 hours and 1/12/10 at 0950 hours, the hospital's RSMC campus ED was toured and the lack of patient privacy was observed on both days:</p> <p>A double doorway served as an exit from the ED into the hallway of the Radiology Department. The long radiology hallway had ED patients on gurneys lining the entire right side of the hallway. A shorter hallway on the left had two patients in gurneys lining the left side which filled the left side to the exit doors. All eight patients, on both days, had no screen or curtain in front of them and all eight patients were visible to people (which included hospital staff and visitors), walking down the hall. On 1/11/10 at 1430 hours, one of the</p>	A1104	

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A1104 Continued From page 138 A1104

unsampled patients was uncovered and had one hand down the front of his pants.

On 4/11/10 at 1430 hours, the surveyor was conducting an interview with Patient 317 in ED Room 3. The room was intended for one patient but there were two patients in the room. A staff members discussion with the other patient was clearly audible at Patient 314's bedside.

4. Review of the hospital's ED policy Structure Standards: Emergency Department, showed assignments would consider patient needs and in another section of the Standards, LVNs receive direction from the Staff Nurse, Charge Nurse and other nurse managers. Additionally, the Structure Standards showed that patient assignments would consider patient needs and staff credentialing and certifications.

On 1/11/10 at 1355 hours M49 stated the RSMC campus ED had three LVNs on staff. At 1500 hours, on 1/11/10 M 49 was asked about the ED patient acuity system. According to M49, the ED used a five level triage system that ranged from Level 1 as the most acutely ill to Level 5 as the least acute patient.

On 1/12/10, review of the Five Level Triage P & P failed to show how the acuity would be used for assignments by staff licensure/qualifications. Further review of the ED policy Structure Standards: Emergency Department failed to show any specific direction of how LVN assignments would be made.

A1112 482.55(b)(2) QUALIFIED EMERGENCY SERVICES PERSONNEL A1112

There must be adequate medical and nursing

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A1112 Continued From page 140

4. PA8 was appointed to the medical staff of the hospital on 4/16/07. A review of the credentials file for PA8 revealed that documentation of proctoring was performed for 9 cases on 4/30/08. This did not comply with the medical staff bylaws of the hospital that specify 10 concurrent and retrospective case reviews. When interviewed on 1/14/10 at approximately 1440 hours, PA 8 stated that she was unaware of her "responsibility to initiate contact with her proctor when treating a patient."

5. The professional credentials file for PA10 revealed that proctoring was performed for 10 cases on the same date. There was no written documentation that the medical records review was consistent with the medical staff bylaws that require concurrent and retrospective case review.

6. On 1/11/10 at 1350 hours, an interview was conducted with PA 11. PA 11 was sitting in a room designated as a MSE room. MSEs are patient examinations done to determine if a patient has an emergency medical condition. PA 11 stated that she did MSEs for ED patients and ordered tests and treatments.

On 1/12/10, a review of the credential file for PA 11 failed to show any written evidence of proctoring as required by the Medical Staff bylaws prior to appointment by the medical staff.

A1112

A1160 482.57(b) RESPIRATORY CARE SERVICES POLICIES

A1160

Services must be delivered in accordance with medical staff directives.

This STANDARD is not met as evidenced by:
Based on interview and document review, the

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A1160 Continued From page 141 A1160

hospital failed to ensure the Respiratory Care Service's policy and procedures addressed staff competency for emergency intubation procedures which could potentially result in patient injury.

Findings:

On 1/12/10, review of the policy and procedure "Endotracheal Intubation" showed that appropriate personnel "skilled in intubation" should be assembled but did not define what constituted skilled in intubation. Also, the P&P showed that RCPs intubated infants, children, and adults.

On 1/12/10 at 1610 hours, during an interview E116 stated the RCPs competencies for the past year included neonatal intubation but did not include competencies for children and adults. E116 also added that RCPs intubated about 5 neonates a month. E116 stated the RCPs rarely intubated adults or children; usually the ED physician or an anesthesiologist intubated these patients.

On 1/13/10 at 1015 hours during interview, M53 stated that usually the ED physicians responded and performed emergency intubations in the hospital. M53 went on to confirm M52's statement that RCPs rarely intubated infants and adults but went on to add that the intubation policy allowed them to intubate in the event the ED physician was unavailable. When asked what competencies were in place for adult and pediatric intubation, M53 stated the RCPs had to have PALS (Pediatric Advanced Life Support) and ACLS (Advanced Cardiac Life Support). PALS and ACLS are courses offered through the American Heart Association but does not ensure continued

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A1160	Continued From page 142 competency.	A1160		