DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

Refer to: WCDSC-

August 10, 2007

Antoinette Epps, Hospital Administrator
Martin Luther King, Jr.- Harbor Hospital
12021 South Wilmington Avenue
Los Angeles, CA 90059

CCN: 05-0578

Dear Ms. Epps:

We regret to inform you that the most recent survey of Martin Luther King, Jr. - Harbor Hospital ("MLK-Harbor") has revealed that the hospital is not in compliance with a number of Medicare Conditions of Participation (CoPs). Pursuant to the terms of the Extension Agreement signed by the parties on March 30, 2007 and by operation of paragraph C.4 of that Agreement, we are, therefore, notifying you that the Medicare provider agreement with the hospital will be terminated effective August 15, 2007. This decision is final. In accordance with Paragraph C.4 of the Extension Agreement, the termination will not be stayed nor the effective date extended for any reason.

The Centers for Medicare and Medicaid Services ("CMS") is taking this action pursuant to the authority of the Secretary of the United States Department of Health and Human Services to protect the health and safety of Medicare patients by enforcing compliance with statutory requirements and Medicare Conditions of Participation applicable to all Medicare-certified hospitals. 42 U.S.C. 1395cc(b)(2); 42 U.S.C. 1395x(e); 42 C.F.R. Part 482.

In recognition of the health care needs and interests of the residents of South Los Angeles, for the past three years CMS has worked with the administration of MLK-Harbor and the Los Angeles County Department of Health Services, providing technical assistance and allowing ample time for the hospital to plan and implement the measures necessary to achieve and maintain compliance with Medicare health and safety standards. Nevertheless, as you know, repeated certification surveys and complaint investigations have identified serious health and safety violations and documented the hospital's inability to comply with these federal standards. Although there has been commendable recent progress, the latest, and final, comprehensive survey completed on July 27, 2007 again found the hospital out of compliance, documenting condition-level violations in the following areas:

42 C.F.R. §482.12 – Governing Body
42 C.F.R. §482.13 – Patients' Rights
42 C.F.R. §482.21 – Quality Assessment/ Performance Improvement
42 C.F.R. §482.23 – Nursing Services
42 C.F.R. §482.25 – Pharmaceutical Services
42 C.F.R. §482.41 – Physical Environment
42 C.F.R. §482.42 – Infection Control
42 C.F.R. §482.55 – Emergency Services

The following examples are representative of serious problems identified in the most recent survey.

In the area of Patient Rights, Nursing and Emergency Services (42 CFR 482.13, 482.23 and 482.55), the survey identified a very serious lack of supervision for those patients in the emergency department for treatment because they are a danger to themselves or others with suicidal intentions. By failing to assess the patients' needs, secure their belongings and provide continuous one-to-one monitoring as required by the hospital's own policy, a patient had access to a scalpel and cut both of her lower arms. Other similar patients retained their belongings and were allowed unsupervised access to a locked bathroom with their belongings. The survey team determined these practices created imminent danger to patients and declared "immediate jeopardy" on July 24, 2007. Implementation of the plan of correction was verified and the jeopardy was removed on July 27, 2007.

In the area of Infection Control (42 CFR 482.42), patients were placed at serious risk for exposure to contagions, such as tuberculosis, by a failure to clean and track bronchoscopes (flexible endoscopes that come in contact with mucous membranes) in accordance with manufacturer recommendations and standards of practice. Patients receiving dialysis were placed at serious risk for exposure to infectious disease when the hospital failed to ensure that a closed system was maintained during hemodialysis. The dialysate solution (the chemical that takes the wastes and extra fluids trapped by the dialyzer and carries them away from the blood) was in use with the solution exposed to the air, thus also potentially exposing patients to infectious diseases.

In the area of Nursing and Pharmaceutical Services (42 CFR 482.23, 482.25), patients were placed at serious risk when the hospital failed to adequately assess and take subsequent corrective action to assure staff's ability to respond timely and appropriately to a "mock" pediatric emergency drill. During observation of one such drill, surveyors noted hospital staff were unable to locate critical equipment and medications on the pediatric emergency cart, nor were they able to correctly calculate dosages for medication administration to pediatric patients. The hospital staff's inability to render an adequate emergency response in a mock situation leaves pediatric patients vulnerable during an actual emergency, where staff competency and time are of the essence.

In the area of Quality Assessment/Performance Improvement and Pharmaceutical Services (42 CFR 482.21, 482.25), patients were placed at risk when the hospital failed to analyze pharmacy data adequately for medication errors. The pharmacy performance improvement project uses the National Council for Medication Error Reporting and Prevention categories to collect data on medication errors within the hospital, breaking them down into nine specific categories, including Error no Harm, Error with Harm, and Error/ Death. However, the hospital pharmacy failed to adequately analyze the data collected in order to identify and correct systems problems that may lead to medication errors.

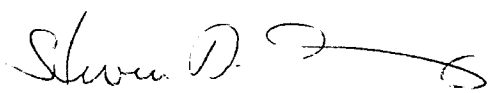
The findings establishing these and other violations were summarized at a face-to-face exit conference with hospital administrators on August 10, 2007 and are detailed on the attached Statements of Deficiencies (CMS Form 2567).

Following termination of the provider agreement, MLK-Harbor may apply for reinstatement to the Medicare program. See 42 C.F.R. 489.57. However, a new Medicare provider agreement will not be accepted unless CMS determines that the reason(s) for termination of the previous agreement has been remedied and that there is "reasonable assurance" that the hospital can maintain compliance with the applicable Conditions of Participation. 42 C.F.R. 489.57(a). Compliance will be verified for this purpose by on-site surveys conducted at the beginning and end of a reasonable assurance period determined by CMS. This period will be a minimum of 90-120 days. Prior to issuance of a new provider agreement, the hospital also must fulfill, or make satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of its previous agreement. 42 C.F.R. 489.57(b).

We note that, pursuant to Paragraph C.5 of the Extension Agreement signed by the parties on March 30, 2007, the hospital, in exchange for the additional time for the hospital to correct its deficiencies, agreed to relinquish any appeal rights, administrative or judicial, to challenge this termination decision.

Any questions may be directed either to the undersigned at 415-744-3682 or to the Manager for Hospital and Community Care Operations, Michelle Griffin, at 415-744-3687.

Sincerely,



Steven D. Chickering
Western Consortium Survey and Certification Officer
Division of Survey and Certification

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050578	A. BUILDING _____ B. WING _____	07/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER KING, JR - HARBOR HOSPITAL	12021 S WILMINGTON AVE LOS ANGELES, CA 90059

(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 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a full re-certification survey conducted 7/23/07 through 7/27/07. Complaint #CA 00121354 and #CA 00122183 were investigated during the survey. Representing the California Department of Public Health: Barbara Mellor, HFEN JoAnn Dalby, HFES Charles Derby, Medical Consultant Alan Kratz, Medical Consultant Leticia Creighton, HFEN Francia Trout, Health Records Consultant Joseph Cano, Pharmacy Consultant Maelin Yee, Rehabitation Consultant Linda Handy, Nutrition Consultant The hospital's census at the beginning of the survey was 48. The survey sample size was 98 open and closed medical records. The findings for Complaint #CA00122183 are written at 482.13(c)(1). The findings for Complaint #CA00121354 are written at 482.13(c)(2) At 1700 hours on 7/24/07, hospital administration was notified of immediate jeopardy (IJ) to the health and safety of all patients presenting to the emergency department (ED) for treatment. The hospital failed to ensure Patient #54's right to receive care in a safe setting. The failure to	A 000		

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

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

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A 000	Continued From page 1 assess the patient's needs, secure the patient's belongings and provide 1:1 staffing, as required by hospital policy and procedure, resulted in the patient being able to access a scalpel and cut both lower arms. Additional patients in the ED with suicidal ideation were observed to have their belongings in close proximity, and/or were left alone with their belongings while inside of locked bathrooms. At 1915 hours on 7/24/07, a written plan to ensure the safety of patients presenting that night to the ED was received. A more detailed plan for correction of the IJ situation was received at 1330 hours on 7/26/07. On 7/27/07 implementation of the plan of correction was verified. At approximately 1500 hours on 7/27/07, hospital administration was notified that the IJ situation was abated.	A 000		
A 006	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: Based on observations, interviews, document reviews and record reviews, the hospital failed to have an effective governing body that was responsible for the conduct of the hospital as an institution in meeting the following Conditions of Participation.	A 006		

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A 006	Continued From page 2 Findings: 1. 42 CFR §482.13 the Condition of Participation: Patient ' s Rights - the hospital failed to protect and promote the rights of each patient in accordance with regulations under §482.13. Refer to A-038. 2. 42 CFR §482.21 the Condition of Participation: Quality Assessment and Performance Improvement - the hospital, its governing body and its medical staffed failed to: develop, implement and maintain an effective, ongoing, hospital-wide, data-driven, quality assessment and performance improvement program. The hospital's governing body: 1) failed to ensure that the program is effective; 2) failed to ensure that the program is data-driven; 3) failed to ensure that the program reflected the complexity of the hospital's organization and services, and 4) failed to involve all hospital services. Refer to A-141. 3. 42 CFR §482.23 the Condition of Participation: Nursing Services - the hospital failed to have an organized nursing service that provides 24-hour nursing services that was furnished by and supervised by registered nurses in accordance with regulations under §482.23. Refer to A-199. 4. 42 CFR §482.25 the Condition of Participation: Pharmaceutical Services - the hospital failed to provide pharmaceutical services that meet the needs of the patients in accordance with regulations under §482.25. Refer to A-247 5. 42 CFR §482.41 the Condition of Participation: Physical Environment - Based on the findings of the Life Safety Code Survey, the hospital failed to	A 006		

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A 006	Continued From page 3 be constructed, arranged, and maintained to ensure the safety of the patients. §482.41. Refer to A-321. 6. 42 CFR §482.45 the Condition of Participation: Infection Control - The governing body had failed to ensure that the hospital provided a sanitary environment to avoid sources and transmission of infections and communicable disease. The governing body failed to ensure that the hospital has an Infection Control Program that was an active program for the prevention, control, and investigation of infections and communicable disease. Refer to A-383. 7. 42 CFR §482.55 the Condition of Participation: Emergency Services - the hospital failed to meet the emergency needs of patients in accordance with acceptable standards of practice in accordance with regulations under §482.55. Refer to A-452. The cumulative effect of these systemic practices resulted in the failure of the hospital to deliver statutorily mandated compliance with the Condition of Participation: Governing Body, CFR §482.12.	A 006		
A 031	482.12(f)(1) EMERGENCY SERVICES If emergency services are provided at the hospital, the hospital must comply with the requirements of §482.55. This STANDARD is not met as evidenced by: Based on observations, interviews, document reviews and record reviews, the hospital failed to comply with the requirements of 42 CFR §482.55,	A 031		

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A 031	Continued From page 4 the condition of Participation for Emergency Services. Findings: The hospital failed to meet the emergency needs of patients in accordance with acceptable standards of practice. Refer to A-452.	A 031		
A 038	482.13 PATIENTS' RIGHTS A hospital must protect and promote the rights of each patient. This CONDITION is not met as evidenced by: Based on observation, interview and document and medical record review, the hospital failed to protect and promote the rights of each patient. Findings: 1 The hospital failed to ensure that patients had the right to personal privacy. Refer to A 0056. 2. The hospital failed to ensure that patients had the right to receive care in a safe setting. Refer to A 0057. The failure to assess Patient #54's needs, secure the patient's belongings and provide 1:1 staffing as required by hospital policy and procedure, resulted in the patient being able to access a scalpel and cut both lower arms. Additional patients in the ED with suicidal ideation were observed to have their belongings in close proximity and/or were left alone with their belongings while inside of locked bathrooms. At 1700 hours on 7/24/07, hospital administration	A 038		

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A 038	Continued From page 5 was notified of immediate jeopardy (IJ) to the health and safety of all patients presenting to the emergency department (ED) for treatment. At 1915 hours on 7/24/07 a written plan to ensure the safety of patients presenting that night to the ED was received. A more detailed plan for correction of the IJ situation was received at 1330 hours on 7/26/07. On 7/27/07 implementation of the plan of correction was verified. At approximately 1500 hours on 7/27/07, hospital administration was notified that the IJ situation was abated. 3. The hospital failed to ensure that patients had the right to access information contained in his or her clinical records within a reasonable time frame. Refer to A 0061. The cumulative effect of these systemic practices resulted in the failure of the hospital to deliver statutorily mandated compliance with the Condition of Participation: Patient's Rights 482.13.	A 038		
A 056	482.13(c)(1) PERSONAL PRIVACY The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on observation and staff interview, the hospital failed to ensure patient privacy in the main ER service area. Patients receiving care in the ER had their names, ages and treatment locations listed on a large grease or erasure board. The board was posted on a wall located in a busy and public hallway of the emergency room.	A 056		

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A 056	Continued From page 6 Findings: A tour of the emergency services department was conducted at approximately 1105 hours on 7/23/07. Upon entry into the ER, a large white grease/erasure board was noted to be posted on a wall across from a nursing station. The board was noted to list the location, ages and names of the patients currently receiving treatment in the ER. Interviews conducted with ER staff members revealed that the information written on the board was used to track patient care. The board could be seen and read by patients, family members and/or visitors entering the ER. The names of patients were altered in an attempt to protect privacy, but the patient's name could be easily determined or recognized. For example, a patient with the name of Smith was listed on the board as Mith, S.	A 056		
A 057	482.13(c)(2) RECEIVE CARE IN A SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on document and medical record review, interviews and observation, the hospital failed to ensure patients in the emergency room were provided care in a safe environment. The failure to assess Patient #54's needs, secure the patient's belongings and provide 1:1 staffing, as required by hospital policy and procedure, resulted in the patient being able to access a scalpel and cut both lower arms. Additional patients in the ED with suicidal ideation were	A 057		

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A 057	Continued From page 7 observed to have their belongings in close proximity and/or were left alone with their belongings while inside of locked bathrooms. Findings: 1. On 7/24/07, Emergency Department Policy and Procedure #118 for Management of Psychiatric Patients stated that: * Patient's clothing and valuables must be secured, interventions initiated timely and sitter needs identified. * The RN assigns a sitter to the patient who documents patient behavior and interventions hourly. * At no time should the patient be left alone. * The licensed nurse documents on the nursing assessment the assigned sitter's name * The sitter's name is written on the Emergency Room Shift Assignment Sheet. The hospital failed to ensure this policy for patient safety was implemented as follows: At 1000 hours on 7/24/07, the Chief Executive Officer reported an incident to the survey team. Patient #54 was able to obtain a sharp object and cut themselves, while in the emergency room during the early morning hours of 7/24/07. On 7/24/07 the incident was investigated. At 1035 hours Patient #54 was observed walking with staff. The staff stated they were taking the patient for a shower. The patient was observed to have thin tape-like dressings on each lower arm measuring approximately 3 inches long. The skin around the dressings was a normal color.	A 057		

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A 057	Continued From page 8 At 1145 hours Patient #54 was interviewed. The patient related frustration with the hospital staff because they would not listen, to attempts to inform them of prior treatment received, for a skin condition being treated 7/24/07. The patient stated this led to the incident of cutting both arms. The patient refused to say where the sharp object, used for the cuts, was originally obtained but stated that it was taken out of their bag of chips to inflict the cuts. During the interview, the patient's personal belongings were observed at the bedside. The patient stated no one looked in the belongings bag prior to the incident and there was no staff assigned to sit in her room. The patient stated the door to the room might have been closed at the time of the cutting incident. At 1205 hours staff stated they had left Patient #54 in the shower room unattended to allow for patient privacy. There was no visualization of the patient to ensure safety. A review of nurse staffing for the emergency room for the early morning hours of 7/24/07, revealed there were more than three patients in the emergency room requiring "sitters." Only 3 sitters were assigned to the emergency room. Staff interviews revealed a staff member was not assigned to sit with Patient #54. Staff stated there was no policy and procedure for "sitter" duties and a job description for the position was only recently developed. Administrative staff stated that employee files might or might not have evidence that the sitters were aware of their duties when assigned the job of "sitter." A review of the medical record showed Patient #54 was in the emergency room on 7/23/07 with thoughts of suicide with pills. There was no documentation if the patient brought personal	A 057		

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A 057	Continued From page 9 belongings with them and/or their disposition. The patient was transferred to another facility at approximately 2300 hours. Approximately 2 hours later, at 0115 hours on 7/24/07, the patient was brought back to the emergency room with a different chief complaint. The same nurse was assigned to care for the patient and documented that the patient had thoughts of suicide with pills. There was no documentation if the patient brought personal belongings with them and/or their disposition. There was no documented evidence a person was assigned to watch the patient on a 1:1 basis. At approximately 0330 hours, the patient was found by nursing staff outside the emergency room, smoking. Safety police were with the patient. Patient #54 was brought back to the emergency room. At approximately 0400 hours Patient #54 was observed through the window of the room door, cutting both arms with a scalpel. The nurse documented the patient got the scalpel from a bag of Dorito chips. The lot number on the packaging of the scalpel, used by the patient, was the same as the lot number of others observed by surveyors stored in the locked supply area of the emergency room. On 7/24/07 at approximately 1550 hours, observations of patients identified as a danger to themselves were made in the emergency room. Patient #56 was observed with 3 suitcases at the bedside. A handbag was on the bed with the patient. These belongings had not been secured. Patient # 50 was observed to have a bag of belongings at the head of the gurney. There was a sitter at the bedside. Patient #50 was observed to walk to the bathroom with a bag of personal	A 057		

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A 057	Continued From page 10 belongings and close the door. The door was locked. The sitter stood outside the door. The patient was in the bathroom approximately 5 minutes. Observation of the bathroom revealed glass mirrors and nurse call cords that the patient could have accessed. At 1700 hours on 7/24/07, hospital administration was notified of immediate jeopardy (IJ) to the health and safety of all patients presenting to the emergency department (ED). At 1915 hours on 7/24/07 a written plan to ensure the safety of patients presenting that night to the ED was received. A more detailed plan for correction of the IJ situation was received at 1330 hours on 7/26/07. On 7/27/07 implementation of the plan of correction was verified. At approximately 1500 hours on 7/27/07, hospital administration was notified that the IJ situation was abated. 2. On 7/26/07 at approximately 1030 hours in the emergency room triage area, a cart was observed next to the gurney. The cart drawers were open. Inside the drawers were dressing supplies, needles, laboratory specimen tubes and scalpels. A patient was seated in front of the cart. Staff were not monitoring this area for patient safety. At 0930 hours on 7/27/07, the same cart was observed with open drawers and a patient sitting in the chair in front of it. Next to the patient's chair was a small rolling cart. On the top of the cart was a sharp surgical clamp. On the bottom shelf of the cart was a basin with scissors in it. This area was not being supervised by the staff.	A 057		
A 061	482.13(d)(2) ACCESS TO PERSONAL MEDICAL	A 061		

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A 061	Continued From page 11 RECORD The patient has the right to access information contained in his or her clinical records within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits. This STANDARD is not met as evidenced by: Based on patient and staff interviews and a review of a medical record and policy and procedure (P&P), the hospital failed to actively seek to meet the requests of patients for copies of their own medical record. Findings: 1. At 1320 hours on 7/25/07, Patient #126 stated a complaint had been filed with administrative staff and requested to speak with surveyors for assistance in obtaining a copy from the medical record of the pictures of a fluorescein angiogram conducted at the eye clinic. The patient stated the pictures were needed to make a decision about laser treatment for an retinal eye condition. The patient stated he requested the records on 6/27/07 and was told it would take 10 days. After 10 days the patient was told it would take 5 more days. After the five days elapsed the patient was told that there were no pictures for the angiogram. The medical record for Patient #126 showed a written request for Fluorescein angiogram "image copies or pictures" dated 6/27/07. Hospital P&P HA 702 for access to medical records stated that requested copies of medical records would be provided within 15 days after receipt of the	A 061		

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A 061	Continued From page 12 request. On 7/25/07 at approximately 1415 hours staff from the eye clinic stated they had not received a request for the angiogram pictures for Patient #126 prior to 7/25/07. They stated that they could generate the pictures from the angiography machine and have them ready for the Patient by 1600 hours. Documents submitted by medical records staff on 7/26/07 showed that attempts were made to find the pictures requested by Patient #126 on 7/2, 7/5 and 7/6/07, but radiology did not have the images. The patient's request was not actively pursued again until 7/16/07 at which time radiology again told them there were no angiogram pictures. There was no evidence the eye clinic was called until 7/23/07 to obtain a copy of the requested pictures. As of 7/25/07 the copies had not been provided to Patient #126. 2. Interview with Staff HIM-A at 0845 hours on 7/27/07 and review of the " Incomplete Correspondence Report " revealed that there were 32 release of information requests still not completed, as of 7/25/07. These requests were made more than 15 days ago.	A 061		
A 141	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including	A 141		

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A 141	Continued From page 13 those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on observation, interview, document review and record review the hospital, its governing body and its medical staffed failed to: develop, implement and maintain an effective, ongoing, hospital-wide, data-driven, quality assessment and performance improvement program. The hospital's governing body: 1) failed to ensure that the program is effective; 2) failed to ensure that the program is data-driven; 3) failed to ensure that the program reflected the complexity of the hospital's organization and services, and 4) failed to involve all hospital services. Findings: 1. The QAPI program failed to include an on-going program that showed measurable improvement in indicators for which there was evidence that it would improve heath outcomes. Refer to A 0143. 2. QAPI activities failed to measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations. Refer to A 0145.	A 141		

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A 141	Continued From page 14 3. QAPI activities failed to identify opportunities for improvement and changes that would lead to improvement. Refer to A 0149. 4. QAPI activities failed to focus on high-risk, high-volume, or problem-prone areas. Refer to A 0152. 5. QAPI activities failed to ensure corrective or preventative actions were taken when quality problems were identified. Refer to A 0156. 6. QAPI activities failed to ensure that hospital-wide quality assessment and performance improvement efforts addressed priorities for improved quality of care and that all improvement actions were evaluated. Refer to A 0170. General discussion of the Quality Assessment and Performance Improvement (QAPI) Program: On 7/26/07 during an interview of both the Interim Chief Medical Officer (ICMO) and the Nurse Director of Quality Improvement (DQI) and during a follow-up interview, 7/27/07 with the DQI, the hospital's recent efforts at Quality Assessment and Performance Improvement (QAPI) were discussed. These interviews occurred 7/26/07 at 1415 hours and 7/27/07 at 0845 hours. During these interviews it was presented that the DQI had begun her work at the hospital only eight weeks ago and the ICMO had begun in this current role only five to six weeks ago. Since these two had arrived they had begun a new assessment of the QAPI needs of the hospital and to date they had completed an initial needs assessment of approximately 40% of the inpatient	A 141		

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A 141	Continued From page 15 departments and services, but they had not yet begun a detailed needs assessment of any of the outpatient services. The development of the details of a new QAPI plan for the hospital was still in the concept stages and they had yet to commit to a new written plan, nor to implement it. The hospital was relying in the interim on its current QAPI plan documents and data. On 7/23/07 at 1500 hours the hospital delivered a presentation of their current QAPI program detailing nine specific projects. Eight of the nine projects had been initiated as a result of deficiencies identified during prior CMS (Centers for Medicare and Medicaid Services) surveys. During the interviews of 7/25/07 through 7/26/07 the hospital members were asked to provide evidence of the hospital's required QAPI program data and program activities in addition to the nine QAPI projects. The hospital staff presented the QA Data Binder, a 4 inch thick stack of documents. Data was reviewed in the QA data binder, and neither the ICMO nor the DQI could explain any of the units related to the data numbers related to Infection Control or for the other QA data contained in the binder. The DQI stated, "I thought we had caught that" but had no explanation of what the infection control QA data numbers meant. The hospital's available QAPI data was from the legacy QAPI program; this data had not yet been fully assessed as to validity or meaning and contained recorded numbers without unit values assigned. Consequently there were few, if any, data-driven performance improvement activities in the hospital. At the end of these discussions it was apparent that the hospital had no currently functioning, effective, hospital-wide, data-driven	A 141		

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A 141	Continued From page 16 QAPI program. The cumulative effect of the systemic deficiencies in the current QAPI plan resulted in the failure of the hospital to demonstrate required compliance with the Condition of Participation: Quality Assessment and Performance Improvement, CFR§482.21.	A 141		
A 143	482.21(a)(1) QAPI HEALTH OUTCOMES The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes. This STANDARD is not met as evidenced by: Based on staff interview and review of two of three pharmacy related performance improvement projects (" Turnaround Time for Medication Order " and " 1st Dose IV Antibiotic Order ") the hospital failed to provide adequate evidence that these projects would improve health outcomes or demonstrate measurable improvement as evidenced by the projects being too narrow in scope for evaluation of medication therapy and by combining data collection in a manner that did not allow for demonstration of measurable improvement. Findings: 1. On 7/27/07 at 0925 hours, the performance improvement project for "Turnaround Time for Medication Order" was reviewed. This performance improvement project assessed the time an order was scanned until the time it was delivered and the nurse signed for it. The performance improvement project measured	A 143		

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A 143	Continued From page 17 the average time to process a pharmacy order for: (a) NOW orders (b) STAT orders (c) Emergency Department orders (d) Intravenous (IV) antimicrobial order On 7/27/07 at 0927 hours, Pharmacist 3 said that the reason for this performance improvement project was to measure productivity and efficiency in the pharmacy. It assessed the number of minutes it took for the pharmacy to process and deliver medications. The data points provided failed to demonstrate how this performance improvement project impacted health outcomes. When asked how the pharmacy would know whether or not the medication was administered timely after delivery to the nursing unit or administered accurately, Pharmacist 3 said they wouldn't know. Pharmacy provided a summary sheet for " Medication Turnaround Times," on 7/27/07 at 0935 hours. Review of that document revealed that the outcomes and actions taken were focused on the number of minutes to deliver a medication to the nursing unit. There was no evidence this data was being used to improve patient health outcomes. 2. On 7/27/07 at 1000 hours, the performance improvement project for "1st Dose IV (intravenous) Antibiotic Administration" was reviewed with Pharmacist 3 and Pharmacist 1. The performance improvement project for "1st Dose IV Antibiotic 2007" consisted of measuring the time of the physician order to the time the antibiotic was administered. The stated goal was to be under 120 minutes for the first dose of	A 143		

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A 143	Continued From page 18 antibiotic to be processed and administered to the patient. On 7/27/07 at 1005 hours, Pharmacist 3 stated that they evaluate all IV antibiotics including those ordered, STAT, now and routine. Review of the policy titled, "Medication Administration" at the same time of the interview revealed that the policy for antibiotic administration time frame was 60 minutes for STAT orders and 120 minutes for now and routine orders. Pharmacist 3 could not provide data on what percentage of the orders reviewed were STAT and if, or how, STAT orders significantly lowered the overall data points of less then 120 minutes. Pharmacist 3 could not provide evidence as to whether STAT orders were processed and administered within or under the hospital's 60 minute requirement. Thus the data combined two separate factors into one: whether STAT orders were filled within their 60 minute time frame and whether "now" and "routine" first dose antibiotics were processed and administered within the hospital's 120 minute time frame. Review of the data for this performance improvement project from September 2006 to June 2007, revealed that the stated goal of administration of first dose IV antibiotics within 120 minutes was met. Because of the mixing of data with two different time frame requirements (60 minutes versus 120 minutes) and the fact the number of minutes calculated was an average of all first dose IV antibiotics it was unknown by the hospital whether or not there was measurable improvement in the timeliness of administration of IV antibiotics. In other words, a STAT administered IV antibiotic could have been given	A 143		

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A 143	Continued From page 19 within or greater than the 60 minute time frame but less than 120 minutes and effectively would reduce the overall average number of minutes, rendering data inadequate to support timeliness of IV antibiotic administration. Additionally administration of "routine" or "now" first dose IV antibiotics could be beyond the 120 minute time frame but given that the data was mixed with STAT IV antibiotic administration the overall average number of minutes would be reduced, rendering the data inadequate to support timeliness of administration of IV antibiotics. Because of combining of data with different time expectation for administration of IV antibiotics, the hospital was unable to demonstrate measurable improvement as it relates to administration of IV antibiotics ordered STAT as compared to those ordered "now " or "routine."	A 143		
A 145	482.21(a)(2) QAPI QUALITY INDICATORS The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations. This STANDARD is not met as evidenced by: Based on interview with pharmacy staff, the hospital failed to measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations. Findings: 1. On 7/27/07 at 0940 hours, Pharmacists 1, 2	A 145		

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A 145	Continued From page 20 and 3 were interviewed. Pharmacists 1, 2, and 3 were asked what problems were identified by its own surveillance system for consideration as quality assurance and performance improvement projects. On 7/27/07 during the same interview, Pharmacist 1, 2, and 3 could not provide documentation of a pharmaceutical services quality assurance and performance improvement project that was found through its own surveillance system. 2. During an interview on 7/26/07 at 1500 hours, hospital staff stated they did not have a process or policy for identifying patients who had possibly been exposed to contagious diseases or patients for which a particular a bronchoscope had been used. One of the bronchoscopes had been used on a patient with active TB Refer to A 0340. 3. During an interview on 7/27/07 at 1050 hours, hospital staff stated that infection control staff were notified when the dialysate and water cultures for hemodialysis did not meet pre set standards. Hospital staff also stated that historically the infection control data was not communicated outside the infection control department. As a result, the infection control issues were not being reported to the QAPI committee nor was the medical staff or governing body being informed. Refer to A 0340	A 145		
A 149	482.21(b)(2)(ii) QAPI IDENTIFY IMPROVEMENT The hospital must use the data collected to identify opportunities for improvement and changes that will lead to improvement.	A 149		

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A 149	Continued From page 21 This STANDARD is not met as evidenced by: Based on staff interview and review of two of three pharmacy related performance improvement projects ("1st Dose Intravenous Antibiotic," and "Medication Events"), the hospital failed to use the data collected to identify opportunities for improvement and changes that would lead to improvement. Findings: 1. On 7/27/07 at 1000 hours, the performance improvement project for "1st Dose IV Antibiotic Administration, " was reviewed with Pharmacist 3 and Pharmacist 1. The performance improvement project for "1st Dose IV Antibiotic 2007," consisted of measuring the time of the physician order to the time the drug was administered. The goal was 120 minutes for the first dose of IV antibiotics to be processed and administered to the patient. On 7/27/07 at 1005 hours, Pharmacist 1 and Pharmacist 3 said that the data points for "1st Dose IV Antibiotic 2007" were reported to the Pharmacy and Therapeutics committee in an aggregate format. The data presented represented an average of time from when the physician ordered the antibiotic to administration by nursing staff for all patients in a given month. The aggregate format of the data presented, failed to promote the hospital's ability to identify opportunities for improvement. The data failed to show clinical unit performance on this quality assurance project. For example; when Pharmacist 1 and 3 were asked as to how individual clinical units performed they responded	A 149		

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A 149	Continued From page 22 that Unit 4A was an outlier. Pharmacist 1 and 3 could not explain why the unit was an outlier and or what opportunities existed for improvement. 2. On 7/27/07 at 1015 hours, the performance improvement project titled, Medication Events, was reviewed with Pharmacist 1 and Pharmacist 3. The Medication Events performance improvement project used the National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP) categories which breaks down medication errors into nine specific categories (A, B, C, D, E, F, G, H and I) The medication error categories are grouped as follows: No Error (A), Error no Harm (B, C, D), Error with Harm (F, G, H) and Error, Death (I). On 7/27/07, during the same interview, Pharmacist 1 and Pharmacist 3 were asked if the data in each category was analyzed. Pharmacist 1 and Pharmacist 3 said that data in each category was not analyzed. The Medication Events performance improvement project tracked and provided data, but since the data was not analyzed within each category, there was no correlation of how the data led the hospital to identify and correct systems that may have lead to the medication errors.	A 149		
A 152	482.21(c)(1)(i-iii) QAPI IMPROVEMENT PRIORITIES The hospital must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes and quality of care;	A 152		

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A 152	Continued From page 23 This STANDARD is not met as evidenced by: Based on observation, interview and document review, the hospital failed to ensure that quality assessment performance improvement (QAPI) activities focused on high risk, high volume, or problem prone areas. In addition, the hospital failed to adequately assess physician and nursing staff members' ability to safely and accurately provide and administer medications during a pediatric emergency. Findings: 1. During an interview on 7/26/07 at 1500 hours, hospital staff stated the hospital wide infection control plan was based on the national patient safety goals with additional direction from the Los Angeles Department of Health Services. Hospital staff stated that this data was used to develop their QAPI plan. It was noted that the QAPI plan did not include or focus on the following high risk, high volume or problem prone areas: a. Four of the five areas where flexible endoscopes (instruments that touch mucous membranes or non-intact skin) were cleaned and stored were not in compliance with hospital policy or manufacturer guidance. QAPI activities failed to identify the lack of staff training for processing and storage of endoscopes. b. The QAPI plan did not include a process for identifying all bronchoscopy (endoscope inserted in the airway) patients after the	A 152		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 152	Continued From page 24 possibility of exposure to infectious or communicable diseases. c. The QAPI plan did not ensure that patients who received surgical services at inpatient and outpatient sites received the same level of care by qualified circulating nurses and with plans in place for adequate infection control surveillance, prompt identification of problems, and the need for action. d. The hospital knew of the high incidence of flash sterilization of surgical instruments in September 2006. As of 7/26/07 the QAPI plan did not include monitoring or a plan to decrease the incidence of operating room staff flash sterilizing instruments over 56 percent of the time. Flash sterilization of instrumentation should be used infrequently and not as a substitute for full sterilization processes. e. During interview on 7/27/07 at 1050 hours, hospital staff stated that infection control staff were notified when cultures of the water and dialysate used for hemodialysis did not meet pre-set standards. Hospital staff also stated this data was not communicated outside the infection control department. 2.a. The hospital performs mock codes for assessment of staff 's ability to render medical and nursing care to pediatric patients during an emergency situation such as cardiac resuscitation. A code involving a pediatric patient is referred to as "code pink." The hospital's QAPI program failed to adequately assess staff's ability	A 152		

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A 152	Continued From page 25 to administer medications during a pediatric code (high risk) situation. As a result staff was unable to accurately locate dopamine, dobutamine and epinephrine 1:1000 in the pediatric crash cart in a timely and safe manner. A mock code pink was performed by the hospital on 6/14/07. Review of the Mock Code Blue Skills Sheet Checklist (used for the code pink drill) had the following assessments regarding use of medications: (a) assemble prefilled syringe correctly - ' not applicable' (b) identifies items and respective locations in the crash cart - ' not applicable' (c) verbalizes frequency of the crash cart checks - ' not applicable ' On 7/26/07 at 1242 hours, during a mock code pink with federal surveyors, RN 4 was asked to provide 13.3 grams of dextrose for a pediatric patient with a weight range of 24 kilograms (kgs) to 28 kgs. RN 4 was observed to remove a dextrose 25% (2.5 g per 10 milliliters) Min-I-Jet prefilled Syringe. RN 4 began to use a separate 10 milliliters (mls) syringe to withdraw from the prefilled vial. RN 4 was asked why was that methodology done. RN 4 said, " That was the way we were taught. " The Min-I-Jet Prefilled Syringe system has a vial of dextrose which fits into an injector needle so there would be no need for transferring dextrose from the pre-filled vial to another syringe. The unit assembles quickly by placing the vial into an injector needle which is turned to lock it in and it is ready to administer. On 07/27/07, RN 4 did not demonstrate how to use the Min-I-Jet prefilled	A 152		

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A 152	Continued From page 26 syringe for dextrose 25% per manufacturer instructions. The hospital failed to adequately assess staff's ability to administer medications during a pediatric emergency (high risk situation) as evidenced by the notation on their mock pediatric code performed on 6/14/07. As a result staff was unable to accurately assemble a dextrose pre-filled syringe in a manner that was consistent with manufacturer's guidelines on safe administration. 2b. On 7/24/07 at 1401 hours, in the pediatric urgent care unit the pediatric physician (referred to now as Physician 5) was asked if (s)he ran the pediatric codes (code pinks) in the emergency department (ED) and the pediatric outpatient care unit. Physician 5 said (s)he would run the pediatric codes (code pink) in ED and in the pediatric outpatient unit. Physician 5 was asked what source did (s)he use for dosing pediatric patients during a pediatric code. Physician 5 said it was the Broselow tape (a dosing guideline for pediatric patients based on the length of the patient). Physician 5 was asked how (s)he would use the Broselow tape. Physician 5 said (s)he would call out the drug and the dose and the nurse would remove the drug and draw up the dose. On 7/24/07 at 1422 hours, Physician 5 was asked what would be the standard concentration (s)he would expect the nurse to compound for dopamine and or dobutamine for administration as an intravenous drip. Physician 5 said that dobutamine or dopamine would not be used right away so (s)he would have time to look it up.	A 152		

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A 152	Continued From page 27 On 7/24/07 during the same interview, Physician 5 was asked what (s)he would use to look up the standardized concentration. Physician 5 said (s)he would use her/his PDA to look up the dosing. On 7/24/07, Physician 5 was asked to see the information on his/her PDA. Physician 5 replied that (s)he would use a prescription book and promptly went into another room. Physician 5 came out with a piece of paper and was again asked what were the standard concentrations (s)he would ask the nurse to compound for dopamine and/or dobutamine. Physician 5 responded that the dobutamine would be 2 - 20 mcg/kg/min and the dopamine would be 2 - 20 mcg/kg/min. On 07/27/07, during the same interview the surveyor showed each vial of dopamine and dobutamine (from the pediatric medication tray) to Physician 5 and asked what concentration or standardized concentration would the physician want to compound for or what was the standard concentration for dobutamine and dopamine would be used to compound each drug. Physician 5 said that the dopamine would be 2-20 mcg/kg/min and dobutamine was 2-20 mcg/kg/min. Physician 5 gave a dosage range, but failed to provide the standard concentration (s)he would have the nurse compound for administration of dopamine and dobutamine. The physician's failure to provide guidance to the nursing staff on how to prepare a standardized concentration of dobutamine and dopamine during a pediatric emergent situation did not ensure the medication would be promptly and	A 152		

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A 152	Continued From page 28 accurately given. 2.c. On 7/24/07 at 1550 hours, an emergency room nurse (referred to as RN 5) was asked if (s)he would be the nurse who would respond to a pediatric code (code pink) and pull and draw up the medications for a pediatric code. On 7/24/07, during the same interview Nurse 5 said (s)he would be the nurse. On 7/24/07 at 1551 hours, RN 5 was asked to provide the dose of epinephrine 1:1000 at 3.3 mg or 3.3 ml. On 7/24/07 during the same interview (45 seconds later) RN 5 stated " don't have it would use a calculator to calculate the amount, " which was based on converting a 1:10,000 concentration of epinephrine (s)he found to a concentration of 1:1000. On 7/24/07 after the RN made the previous statement (s)he looked again into the pediatric crash cart where the medication were located and found the epinephrine 1:1000 ampule and handed the ampule and a 3 ml syringe to the surveyor. On 7/24/07 at 1558 hours, RN 5 was asked how (s)he would compound the dopamine and the dobutamine to provide a standard concentration for infusion. On 7/24/07, RN 5 during the same interview said that the pediatric crash cart should have them premixed as in the other hospital she worked at and proceeded to look for the premixed dopamine and dobutamine. On 7/24/07 at 1558 hours, RN 5 could not find the premixed dopamine and dobutamine but found vials of dobutamine 250 mg per 20 ml and dopamine 200 mg per 5 ml. On 7/24/07 during the same interview RN 5, was	A 152		

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A 152	Continued From page 29 asked how (s)he would compound the dopamine and dobutamine. RN 5 said (s)he she would use the pediatric dosing chart which for dopamine was 1.6 mg per ml and the dobutamine was 1 mg/ml. On 7/24/07 at 1558 RN 5 was asked how (s)he would compound either drug to provide the standard concentration for dobutamine and dopamine based on the pediatric dosing chart. RN 5 said that based on the premixed solutions from the other hospital (s)he worked at (s)he would put 40 mls of dobutamine 250 mg per 20 ml in the 500 mls of solution and 400 mg of dopamine (10 mls) in 500 mls of solution. The following issues were: (a) When dopamine 200 mg per 5 ml is compounded to 400 mg in a 500 ml bag the calculated amount of dopamine is 400 mg per 510 ml which would provide a concentration of 0.78 mg per ml which would not be the same as the 1.6 mg/ml required by the pediatric dosing chart used by the staff. (b) When dobutamine 250 mg per 20 ml is compounded to 500 mg per 40 ml to a 500 ml bag the calculated amount would be 500 mg per 520 ml would be 0.93 mg per ml which is not the same as the 1 mg/ml required by the pediatric dosing chart used by the staff. (c) On 7/24/07 RN 5 was unfamiliar and not knowledgeable about which medications were available in the pediatric emergency medication tray located in the pediatric crash cart as evidenced by the inability to locate epinephrine 1:1000 and belief that dopamine and dobutamine	A 152		

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A 152	Continued From page 30 were available as " pre-mixed " intravenous solutions.	A 152		
A 156	482.21(c)(2) QAPI FEEDBACK AND LEARNING Performance improvement activities must implement preventive actions and mechanisms that include feedback and learning throughout the hospital. This STANDARD is not met as evidenced by: Based on staff interview, medical record review and review of the performance improvement project entitled "Medication Events," the hospital failed to implement effective preventative actions and mechanisms that include feedback and learning throughout the hospital. In addition, the hospital failed to utilize observational findings of mock codes to improve the skill level of participants. Findings: On 7/27/07 at 0815 hours, the medical record for Patient #77 was reviewed. Patient #77 had a physician order, written on 6/27/07 at 1500 hours, for " droperidol 0.625mg IV (intravenous) Q6H (every six hours) prn (as needed) N/V (nausea and vomiting)." On 7/27/07 at 0820 hours, a review of the medication administration records (MAR) dated on 06/27/07, and 06/28/07, had " DROPERIDOL INJ Dose: 0.625 MG IVP Give: 0.25ml of 2.5MG per 1ML IVP Q6H PRN N/V " as an active order for both days. On 7/27/07 at 0840 hours, Pharmacist 1 and Pharmacist 2 were asked if the physician order was clarified since droperidol has a blackbox	A 156		

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A 156	Continued From page 31 warning (see warning next paragraph). Pharmacist 2 said the order was clarified by the pharmacist and it was discontinued. The issue was that the droperidol was an " active " order on the MAR since there was no line through it or "discontinue" written for that drug as per policy and procedure entitled " Medication Administration " . Droperidol (Inapsine) has a black box warning from the manufacturer stating that, "cases of QT prolongation and/or torsades de pointes have been reported in patients receiving Inapsine (droperidol) at doses at or below recommended doses. Some cases have occurred in patients with no known risk factors for QT prolongation and some cases have been fatal. " Torsades de Pointes is a cardiac arrhythmia, which may cause blackouts or sudden death. The manufacturer labeling states, all patients should undergo a 12-lead ECG prior to administration of Inapsine (droperidol) to determine if a prolonged QT interval (i.e., QTc greater than 440 msec for males or 450 msec for females) is present. If there is a prolonged QT interval, Inapsine (droperidol) should NOT be administered. The black box warning for droperidol stipulates; " due to its potential for serious proarrhythmic effects and death, Inapsine (droperidol) should be reserved for use in the treatment of patients who fail to show an acceptable response to other adequate treatments. " On 7/27/07 at 1015 hours, the performance improvement project entitled Medication Events was reviewed with Pharmacist 1 and Pharmacist 3.	A 156		

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A 156	Continued From page 32 The performance improvement project goals and objectives were: Proactively identify the possibility of adverse medication events and take preventative action to forestall occurrence of medication error. When medication error occurs, investigate the cause of the error and take corrective actions to prevent reoccurrence of a similar error in the future. Establish and standardize the definition of medication error. The corrective actions/follow up dated November 2006 had the following: Clinical pharmacist rounds was started to monitor the usage of high risk medications, titration medications, etc. When a deficiency is found, the clinical pharmacist provides spot in-service. Multidisciplinary Tracer Team was created and started to conduct rounds three times a week to identify deficiencies and to address them in real time. The clinical pharmacist and multidisciplinary team that were initiated to identify and implement preventive actions failed to identify that a droperidol order that was discontinued was 'active' on the MAR for Patient #77 for two days with no 12 lead ECG for the patient. 2. On 7/26/07, review of two Code Pink drills (a practice session in which a scenario involving a child is used to practice emergency responses) revealed that while there were quality management issues in both, there was no	A 156		

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A 156	Continued From page 33 documentation that preventative actions and mechanisms were implemented. On 3/22/07 a Code Pink drill was called at 1130 hours in the Family Birth Center. Among the quality management issues identified was that the Code Pink pager carried by the anesthesiologist did not alarm. On 6/14/07 at 0945 hours a Code Pink drill was conducted in the pediatric outpatient area. For this drill there was a sign-in sheet, however there was no documentation that an anesthesiologist responded to the page. In an interview on 7/26/07 at 1430 hours the Chairman of the Department of Anesthesia stated that if a pager had not alarmed it should have been sent for repairs. He stated there was a log for the emergency pagers which showed who had the pager and what actions had been taken in case of a problem with the pager. However on 7/27/07 at 1005 hours he stated that the emergency pager log for 3/22/07 and 6/14/07 could not be found. There was no documentation that any corrective actions had been taken or preventative actions implemented to ensure that anesthesiologists attended Code Pink drills.	A 156		
A 170	482.21(e)(2) EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring that the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and that all improvement actions are evaluated.	A 170		

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A 170	Continued From page 34 This STANDARD is not met as evidenced by: Based on interview and document review, the hospital's governing body, medical staff and leadership failed to ensure that all QAPI efforts addressed priorities for improved quality of care. In addition, these entities failed to ensure improvement actions were evaluated for quality of care as evidenced by an educational program for pharmacist directed Vancomycin and Aminoglycoside dosing initiated by the pharmacy department without coordination and input from leadership of the hospital, other hospital disciplines, or committees. Findings: 1. The QAPI program failed to include an on-going program that showed measurable improvement in indicators for which there was evidence that it would improve heath outcomes. Refer to A 0143. 2. QAPI activities failed to measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations. Refer to A 0145. 3. QAPI activities failed to identify opportunities for improvement and changes that would lead to improvement. Refer to A 0149. 4. QAPI activities failed to focus on high-risk, high-volume, or problem-prone areas. Refer to A 0152. 5. QAPI activities failed to ensure corrective or preventative actions were taken when quality	A 170		

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A 170	Continued From page 35 problems were identified. Refer to A 0156. 6. On 7/27/07 at 0910 hours, an Aminoglycoside Dosing and Monitoring in Adults and a Vancomycin Dosing and Monitoring in Adults policy were reviewed. Both aminoglycoside and vancomycin are medications used to treat infections. Both policies provided guidance on how a pharmacist would assess, select a dose and monitor a patient prescribed an aminoglycoside or vancomycin medication. Further review of these policies, in addition to interview with Pharmacist 1 and 4, on 7/27/07 at 0910 hours, revealed that the pharmacy department had educated pharmacist staff on the content of the policy, including assessing competency with administration of a post test. Pharmacist 1 stated that all of the pharmacists had been educated on the policy and additionally had completed a post test for competency. On 7/27/07 at 0910 hours, Pharmacist 1 and Pharmacist 4 were asked if the two policies had been reviewed and approved by appropriate committees, such as but not limited to Pharmacy and Therapeutics. Pharmacist 1 said " No. " Pharmacist 1 also stated that the pharmacy was anticipating on providing pharmacist initiated dosing for aminoglycoside and vancomycin as an improvement activity related to use of these medications. Pharmacist 4 was asked if an infectious disease physician had provided input in the development of the vancomycin or aminoglycoside policy, to ensure what was being taught to the pharmacists, was what infectious disease physician(s) would be doing or expecting of the pharmacists.	A 170		

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A 170	Continued From page 36 Pharmacist 4 indicated that infectious disease physician(s) were not consulted in the development of the policy or the pharmacist educational program. The pharmacy department developed a policy and educational program for pharmacist directed dosing of aminoglycosides and vancomycin, without being directed by the hospital leadership and ensuring input from other disciplines (e.g. infectious disease physician) and committees (e.g. pharmacy and therapeutics) to ensure quality of care related to medication therapy.	A 170		
A 199	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, patient and staff interviews, review of hospital documentation and medical record reviews, the hospital failed to: 1. Ensure adequate numbers of nursing and other personnel to meet the needs of patients. Refer to A 0201. 2. Ensure a registered nurse supervised and evaluated the care of each patient in the emergency room. Refer to A 0204. The cumulative effect of these systemic practices resulted in the failure of the hospital to deliver statutorily mandated compliance with the Condition of Participation: Nursing Services, CFR	A 199		

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A 199	Continued From page 37 §482.23.	A 199		
A 201	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on observations, interviews and medical record and document reviews, the nursing service failed to ensure adequate numbers of qualified nursing and other personnel to provide for the safe care of psychiatric patients in the emergency room. In addition, nursing services failed to ensure that nurses providing care to patients in emergency and surgical service areas were qualified to do so. Findings: 1. On 7/24/07, Emergency Department Policy and Procedure #118 for Management of Psychiatric Patients stated that: * The RN assigns a sitter to the patient who documents patient behavior and interventions hourly. * At no time should the patient be left alone. The nursing service failed to ensure this policy for safe patient staffing was implemented as follows:	A 201		

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MARTIN LUTHER KING, JR - HARBOR HOSPITAL	12021 S WILMINGTON AVE LOS ANGELES, CA 90059

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A 201	Continued From page 38 A review of nurse staffing for the emergency room for the early morning hours of 7/24/07 revealed there were more than three patients in the emergency room requiring "sitters." Only 3 sitters were assigned to the emergency room. Staff interviews revealed a staff member was not assigned to sit with Patient #54. A review of the medical record showed Patient #54 was in the emergency room on 7/23/07 with thoughts of suicide with pills. The patient had a sitter assigned. The patient was transferred to another facility at approximately 2300 hours. Approximately 2 hours later, at 0115 hours on 7/24/07, the patient was brought back to the emergency room with a different chief complaint. The same nurse was assigned to care for the patient and documented that the patient had thoughts of suicide with pills. There was no documented evidence a person was assigned to watch the patient on a 1:1 basis. At approximately 0330 hours the patient, was found by nursing staff, outside the emergency room smoking. Safety police were with the patient. Patient #54 was brought back to the emergency room. At approximately 0400 hours Patient #54 was observed through the window of the room door, cutting both arms with a scalpel. The nurse documented the patient got the scalpel from a bag of Dorito chips brought in by the patient. The lot number on the packaging of the scalpel used by the patient was the same as the lot number of others observed by surveyors stored in the locked supply area of the emergency room.	A 201		

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A 201	Continued From page 39 2 . On 7/23/07 an observational tour of the emergency service areas was conducted. Interviews conducted with staff members identified that emergency services included the main emergency room (ER), adult urgent care and the pediatric urgent care. Patients would present to the main emergency area where the patients would be assessed/triaged by a nurse for appropriate category. Patients assessed as category I, II or III identified as having more serious injuries or illnesses were to be seen and treated in the main ER, while patients assessed as category IV or V would be treated in either the adult urgent care or pediatric urgent care (PUC) based on age. Interviews conducted with PUC nursing staff members on 7/23/07 revealed that patients from newborn to 17 1/2 (teenagers) years of age received treatment in their service area. Patients seen and treated in the PUC were either directed from the main ER or were seen for follow-up of an emergency condition. Pediatric patients that required routine clinic care or scheduled appointments received care in an outpatient pediatric clinic. On 7/23/07, the unit was observed to have two crash/code carts. One cart was a pediatric crash cart and the other was an adult crash cart. The pediatric crash cart was color coded to coincide with the Broselow tape. The Broselow tape is a tool for determining the correct dosage of medication and equipment sizes (endotracheal tubes, suction catheters) for children based on length. For each color identified, instructions were listed on the tape identifying medication dosages needed for	A 201		

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A 201	Continued From page 40 pediatric resuscitation. The tape registered medication dosages for patients from 3 kg (kilograms) or 6.6 pounds to 36 kg. or 79.2 pounds. The tape is not intended to be utilized for patients over the age of 12 years. Pediatric patients aged 12 years or over and weighing greater than 80 pounds, would require medications stored in the adult crash cart. In addition, any child under the age of 12, whose length exceeds the tape should be treated with adult doses of emergency medications and equipment. Review of the hospital policy titled, Code Pink, reviewed and revised in July 2007, identified that a Code Pink Team responded to all Code Pink pages. The policy identified that the code pink team was made up of a PALS (pediatric advanced life support) certified pediatric physician, an ACLS (advanced cardiac life support) certified anesthesiologist, an ACLS and PALS certified ER nurse and a respiratory therapist. Interviews conducted with pediatric urgent care nursing staff and the director of nursing clarified that the ER nurse identified in the policy was a pediatric urgent care nurse. Pediatric Advance Life Support (PALS) is a course that is designed to provide caregivers with skills, which would enable them to both recognize the potential for respiratory and/or cardiac arrest in infants and children and to intervene in an effective and efficient manner, resulting in improved outcomes. Advanced Cardiac Life Support (ACLS) is a course that is designed to provide caregivers with skills that would enable them to both recognize	A 201		

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A 201	Continued From page 41 the potential for respiratory and/or cardiac arrest in adult patients and to intervene in an effective and efficient manner, resulting in improved outcomes. The job description for a registered nurse working in the PUC described that the following credentials were required; RN license, BLS (basic life support), PALS, and ACLS certifications. Personnel files were reviewed for four registered nurses (RN 1, RN 2, RN 3 and RN 4), identified as working in the PUC. Four of the four nurses reviewed failed to have ACLS certification. On 7/27/07 a follow up conversation was conducted with the nurse manager of the PUC. The issue of the ACLS requirement for the registered nurses working in the pediatric urgent care was discussed. The nurse manager stated that the requirement to have ACLS certification, as defined in the job description, was a typo (error). Further discussion failed to provide evidence as to how the PUC nurses would be deemed competent to provide life saving measures, including the administration of emergency medications, to adult sized pediatric patients over the age of 12 years or patients weighing greater than 80 pounds. 3. On 7/24/07 at 1402 hours, the surveyor asked pediatric urgent care RN 1 to demonstrate how the nurse would convert the defibrillator for use with the pediatric paddles. RN 1 took 2 minutes and 10 seconds to try to " plug ' in the paddles and when (s)he was done showed the paddles to the surveyor and indicated they were ready.	A 201		

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A 201	Continued From page 42 On 7/24/07 during the same interview, the surveyor asked if the paddles were pediatric paddles; RN 1 took 30 seconds with the help from two other nurses (RN 2 and RN 3) to find and provide the pediatric defibrillator/monitoring pads that would be used with the defibrillator. The paddles originally shown to the surveyor where adult paddles not those used for pediatric patients. It took RN 1 with the help of two other RNs (RN 2 and RN 3) a total of two minutes and 40 seconds to produce the correct pediatric defibrillator/monitoring pads. 4. On 7/26/07 at 0950 hours, an inspection of the room in the surgical clinic where surgical procedures (cystostomy/cystoscopy) were performed, was conducted. The cystoscopy log was reviewed and it showed that on 3/27/07, two cystoscopies were performed. During a concurrent interview, a hospital employee verified that she was the circulating nurse that day. The hospital employee, a nurse manger over the area, stated that she was not a circulating nurse. The nurse stated that circulating nurse assigned to the surgical clinic was on vacation. The nurse manager stated she was just filling in and was "there to sign the papers."	A 201		
A 204	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on document and medical record review,	A 204		

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A 204	Continued From page 43 interviews and observation, the nursing service failed to ensure a registered nurse supervised and evaluated the care of patients in the emergency room. The failure to assess Patient #54's needs, secure the patient's belongings and provide 1:1 staffing as required by hospital policy and procedure, resulted in the patient being able to access a scalpel and cut both lower arms. Patients in the ED with suicidal ideation were observed to have their belongings in close proximity and/or were left alone with their belongings while inside of locked bathrooms. In addition nursing services failed to ensure licensed nurses followed established policies for pain assessment and the administration of pain medication in the emergency department. Findings: 1. On 7/24/07, Emergency Department Policy and Procedure #118 for Management of Psychiatric Patients stated that: *Patient's clothing and valuables must be secured, interventions initiated timely and sitter needs identified. *The RN assigns a sitter to the patient who documents patient behavior and interventions hourly. * At no time should the patient be left alone. * The licensed nurse documents on the nursing assessment the assigned sitter's name * The sitter's name is written on the Emergency Room Shift Assignment Sheet. The nursing service failed to ensure this policy was implemented as follows: At 1000 hours on 7/24/07, the Chief Executive	A 204		

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A 204	Continued From page 44 Officer reported an incident to the survey team. Patient #54 was able to obtain a sharp object and cut themselves while in the emergency room during the early morning hours of 7/24/07. On 7/24/07 the incident was investigated. At 1035 hours Patient #54 was observed walking with staff. The staff stated they were taking the patient for a shower. The patient was observed to have thin tape-like dressings on each lower arm measuring approximately 3 inches long. The skin around the dressings was a normal color. At 1145 hours Patient #54 was interviewed. The patient related frustration with the hospital staff because they would not listen to attempts to inform them of prior treatment received, for the condition being treated 7/24/07. The patient stated this led to the incident of cutting both arms. The patient refused to say where the sharp object used for the cuts was originally obtained, but stated that it was taken out of their bag of chips, to inflict the cuts. During the interview, the patient's personal belongings were observed at the bedside. The patient stated no one looked in the belongings bag prior to the incident and there was no staff assigned to sit in her room. The patient stated the door to the room might have been closed at the time of the cutting incident. At 1205 hours staff stated they had left Patient #54 in the shower room unattended, to allow for patient privacy. There was no visualization of the patient to ensure safety. A review of nurse staffing for the emergency room for the early morning hours of 7/24/07 revealed there were more than three patients in the emergency room requiring "sitters." Only 3 sitters were assigned to the emergency room. Staff interviews revealed a staff member was not	A 204		

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A 204	Continued From page 45 assigned to sit with Patient #54. Staff stated there was no policy and procedure for "sitter" duties and a job description for the position was only recently developed. Administrative staff stated that employee files might or might not have evidence that the sitters were aware of their duties when assigned the job of "sitter." A review of the medical record showed Patient #54 was in the emergency room on 7/23/07 with thoughts of suicide with pills. There was no documentation if the patient brought personal belongings with them and/or their disposition. The patient was transferred to another facility at approximately 2300 hours. Approximately 2 hours later, at 0115 hours on 7/24/07, the patient was brought back to the emergency room with a different chief complaint. The same nurse was assigned to care for the patient and documented that the patient had thoughts of suicide with pills. There was no documentation if the patient brought personal belongings with them and/or their disposition. There was no documented evidence a person was assigned to watch the patient on a 1:1 basis. At approximately 0330 hours, the patient was found outside the emergency room, smoking. Safety police were with the patient. Patient #54 was brought back to the emergency room. At approximately 0400 hours Patient #54 was observed through the window of the room door, cutting both arms with a scalpel. The nurse documented the patient got the scalpel from a bag of Dorito chips. The lot number on the packaging of the scalpel used by the patient was the same as the lot	A 204		

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A 204	Continued From page 46 number of others observed stored in the locked supply area of the emergency room. 2. On 7/24/07 at approximately 1550 hours, observations of patients identified as a danger to themselves were made in the emergency room. Patient #56 was observed with 3 suitcases at the bedside. A handbag was on the bed with the patient. These belongings had not been secured. Patient # 50 was observed to have a bag of belongings at the head of the gurney. There was a sitter at the bedside. Patient #50 was observed to walk to the bathroom with a bag of personal belongings and close the door. The door was locked. The sitter stood outside the door. The patient was in the bathroom approximately 5 minutes. Observation of the bathroom revealed glass mirrors and nurse call cords that the patient could have accessed. 3. Patient #49 presented to the ER on 7/22/07 at 0646 hours with a chief complaint of being hit in the head with a telephone. Nursing documentation at the time of initial complaint revealed that the patient had a scar and abrasion noted to the top of the head. The nurse documented that the patient described having severe pain as evidenced by a pain rating of 10, on a scale of zero to 10, with 10 being the most severe. The location of pain was identified as the patient's "entire head." The nurse failed to complete the initial pain assessment. Missing from the assessment were; pain radiation, when the pain started, what makes it better, what makes it worse, and how long does it last. Review of the medical record revealed that	A 204		

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A 204	Continued From page 47 the patient received Motrin at 0715 hours, Vicodin at 1030 hours and 1515 hours on 7/22/07. Nursing documentation at 0815 hours, 1130 hours, and 1615 hours on 7/22/07 described that the patient's response to receiving pain medications was "good with a down arrow pain" indicating that pain had decreased. The hospital's policy titled, Pain Management, identified that pain assessments were to include intensity, location, quality of pain, onset, duration, validation and patterns, present pain management regimen and effectiveness, and effects of pain. Pain assessments, reassessments and treatment modalities will be documented on unit specific patient record (s). 4. Patient #61 presented to the emergency department on 7/13/07 at 1738 hours, with a chief complaint of chest pain to the left side of his chest. Nursing assessment described the patient as having chest pain all day today with weakness. The patient reported that he was experiencing constant sharp pain with nothing providing relief. The patient described the pain as severe and rated the pain as an 8 on a scale of zero to 10. The patient was triaged as a category III. Nursing documentation failed to provide evidence that the nurse provided the patient with triage care. Triage notes identified that the ER physician was aware of the patient's severe pain. The patient refused to allow nursing staff to place an IV (intravenous) saline lock into his arm(s) for medication administration and was refusing lab draws. The patient was requesting that venipunctures be done on his legs. Physician orders dated and timed as 7/13/07 at	A 204		

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A 204	Continued From page 48 1850 hours revealed the patient could have Amorphine 4 mg IV for pain and 325 mg aspirin orally for cardiac intervention. Documentation revealed that the nurse administered the aspirin but did not give pain medication as the patient did not have an IV. No other form (oral, intramuscular or rectal) of pain medication was provide to the patient. No form of comfort measures to assist in alleviating the patient's pain were provided. The patient continued to have unrelieved severe pain for 4 and 1/2 hours, until 2200 hours, when the patient consented to have an IV saline lock placed and IV Dilaudid 2 mg was given. On June 18, 2007, the hospital provided all triage nurses with a memo regarding quality care in the emergency department. The memo stated that, if patients are assessed with a level of pain that requires intervention to relieve pain, call immediately for, and administer pain relief measures (therapeutic and non-therapeutic).	A 204		
A 223	482.24(b) FORM AND RETENTION OF RECORDS The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. This STANDARD is not met as evidenced by: Based on medical record review, the hospital failed to maintain a medical record for each inpatient and outpatient that was accurately	A 223		

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A 223	Continued From page 49 written. The hospital failed to identify the context in which abbreviations were to be used or by using the approved meaning of the abbreviation. Findings: 1. Patient #49 presented to the ER on 7/22/07 at 0646 hours with a chief complaint of head injury. During the patient' stay the patient was identified as being depressed with suicidal ideation. Nursing documentation on 7/23/07 at 0800 hours detailed that the patient was on a 5150 legal hold. Documentation revealed that Patient #49 was transferred, via ambulance, to a local hospital for a higher level of care. Review of the medical record failed to provide evidence of the 5150 legal hold, evidence of required transfer documents and a discharge summary. The Emergency Nursing Flow Sheet form, failed to have documentation that the patient's triage disposition and time to treat ment area were completed. In addition, review of the Emergency Department History and Physical form failed to identify the patient's condition (improved, stable, unstable or critical) or the patient's disposition time required to be completed by a physician. 2. Patient #47 presented to the ER on 7/22/07 at 1400 hours with a chief complaint of dizziness and "heart fast." Review of the Emergency Department History and Physical form required to be completed by a physician failed to identify the time the physician saw the patient, the age of the patient and the disposition time the patient was admitted. In addition, the medical record failed to contain a nursing discharge assessment.	A 223		

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A 223	Continued From page 50 3. Patient # 60 was sen in the emergency department on 7/7/07. The patient was to be transferred to another local hospital for on-going care. The patient identified that she would prefer to go to a different hospital. Review of the Patient Refusal of Care or Transfer form, contained in the medical record, was blank, except for the signature of a family member. There was no evidence that the patient had been notified of the risks and benefits of transfer. There was no documented evidence that the physician, providing care to the patient, had spoken to the patient regarding the transfer as the physician had not signed the transfer form. 4. At 1230 hours on 7/24/07, the medical record for Patient #54 contained a Patient Transfer Summary and Acknowledgement form. The date of signature was written over and could have been 7/22/07 or 7/24/07. The same signature appeared in both the " patient " and the " physician " signature space. The form contained a " witness " signature by the hospital staff. Areas for information regarding diagnosis, treatment, condition, receiving facility, " transfer checklist, " and " physician certification " were blank. 5. The hospital 's policy #09-305, " Standard Abbreviations, Acronyms and Symbols " was reviewed on the morning of 7/24/07. The approved abbreviation list contained at least 16 abbreviations that had more than one meaning; for example, " ARF " = acute respiratory failure/acute renal failure; " BE " = barium enema/below elbow; " BS " bowel sounds/blood sugar; " HA " = headache/hearing aid; " LS " = lumbosacral/liver scan; " MS " = multiple	A 223		

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A 223	Continued From page 51 sclerosis/mitral stenosis/musculoskeletal; " PET " = pre-eclamptic toxemia/Psychiatric Emergency Team/positron emission tomography. 6. The medical record of Patient #126 was reviewed the morning of 7/26/07. On the Ophthalmology Follow-Up Examination clinic note for 5/29/07, the abbreviation " FA " was written in the " Auxiliary Tests " section. The approved meaning for this abbreviation is " fatty acid," however, the intended meaning was "fluorescein angiogram," according to Staff HIM-A during an interview later the morning of 7/26/07. 7. The medical record of Patient #103 was reviewed at 1445 hours on 7/26/07. The patient was registered on 4/5/07 at 0600 hours and a heart catheterization was performed. The patient left the hospital on 4/6/07 at approximately 1430 hours (more than a 30-hour stay). On the Admission Information section of the Facesheet (registration form), the patient was recorded as being an "Outpatient " in the "Same Day Surgery " division/service. The record was filed on the left side of the chart folder, which is for the outpatient records. Interview with Staff HIM-A and MD-C on 7/27/07 at 1120 hours revealed that the patient was intended to have been admitted as a one-day, inpatient hospitalization, as documented on the " Scheduled Admission Request " form; however this was not done by the registration staff.	A 223		
A 247	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area	A 247		

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A 247	Continued From page 52 under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This CONDITION is not met as evidenced by: Based on record review, interview and observation the facility failed to provide pharmaceutical services to meet the needs of the patient as evidenced by failure to ensure: 1. Staff is able to access and utilize medications and supplies for pediatric emergencies in a safe and timely manner. Refer to A 0252. 2. Supplies necessary to administer medications during a pediatric emergency are available. Refer to A 0252. 3. Nursing medication administration record accurately reflects discontinued medications and that this is identified by pharmacists during their clinical rounds. Refer to A 0252. 4. Pharmacy provides input on the safe use and storage of pediatric emergency medications. Refer to A 0252. 5. Policies and procedures related to ordering and monitoring of antibiotics (i.e. aminoglycosides and vancomycin) are developed with input from other appropriate and applicable hospital disciplines or committees. Refer to A 0252. 6. Two of three pharmacy related performance improvement projects demonstrate measurable	A 247		

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A 247	Continued From page 53 improvement or improve health outcomes. Refer to A 0143. 7. The assessment of care process provided by pharmaceutical services represented those issues independently identified by the facility as in need of improvement and not primarily non-compliance issues identified by state and federal regulatory agencies. Refer to A 0145. 8. The data from one of three pharmacy related performance improvement projects was used to identify opportunities for improvement and changes that would lead to improvement. Refer to A 0149. 9. Performance improvement activities focused on high risk areas of care as evidenced by failure to adequately assess staff 's ability to safely and accurately provide and administer medications during a pediatric emergency. Refer to A 0152. 10. Three of three pharmacy related performance improvement projects demonstrated how the activities affected patient safety. Refer to A 0153. 11. The facility implemented effective preventative actions and mechanisms that include feedback and learning throughout the hospital for performance improvement project on " Medication Events. " Refer to A 0156. 12. Implementation of educational programs for ordering and monitoring of medications are coordinated for input from other hospital disciplines or committees. Refer to A 0170.	A 247		

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A 247	Continued From page 54 The cumulative effect of these systemic practices and issues resulted in the failure of the hospital to deliver statutorily mandated compliance with the Condition of Participation for Pharmaceutical Services.	A 247		
A 248	482.25(a) PHARMACY ADMINISTRATION The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This STANDARD is not met as evidenced by: Based on interview and document review the facility failed to ensure that the pharmacy is administered in accordance with acceptable professional principles as evidenced by the development of policies, procedures and training related to use of aminoglycosides and vancomycin without coordination and input from other hospital disciplines or committees. Findings: On 07/27/07 at 0910 hours, an Aminoglycoside Dosing and Monitoring in Adults and a Vancomycin Dosing and Monitoring in Adults policy were reviewed. Both aminoglycoside and Vancomycin are medications used to treat infections. Both policies provided guidance on how a pharmacist would assess, provide a dose and monitor a patient prescribed an aminoglycoside or Vancomycin medication. Further review of these policies in addition to interview with Pharmacist 1 and 4, on the same date at 0910, revealed that the pharmacy department had educated pharmacist staff on the	A 248		

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A 248	Continued From page 55 content of the policy including assessing competency with administration of post test. Pharmacist 1 stated that all of the pharmacists had been educated on the policy and additionally had completed post test for competency. Before a pharmacist could engage in pharmacist directed dosing and monitoring of aminoglycosides or vancomycin the patient ' s physician would have to direct the pharmacist to manage the patient ' s dosing and monitoring of the antibiotics. On 07/27/07 at 0910 hours, Pharmacist 1 and Pharmacist 4 were asked if the two policies had been reviewed and approved by appropriate committees such as but not limited to the Pharmacy and Therapeutics, Pharmacist 1 said " No " . Pharmacist 1 also stated that the pharmacy was anticipating on providing pharmacist initiated dosing for aminoglycosides and vancomycin. Pharmacist 4 was asked if the infectious disease physician had provided input in the development of the Vancomycin or Aminoglycoside policy to ensure what was being taught to the pharmacists was what the infectious disease physician(s) would be doing or expecting of the pharmacists. Pharmacist 4 indicated that the infectious disease physician(s) were not consulted in the development of the policy or procedure or execution of the pharmacist educational program. The pharmacy department developed a policy, procedure and educational program for pharmacist directed dosing of aminoglycosides and vancomycin without ensuring input from other disciplines (e.g. infectious disease physician) and committees (e.g. pharmacy and therapeutics) to	A 248		

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A 248	Continued From page 56 ensure quality of care related to medication therapy.	A 248		
A 252	482.25(b) CONTROL AND DISTRIBUTION OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This STANDARD is not met as evidenced by: -Based on staff interview, medical record review and observation the hospital failed to control and distribute medications in a manner to provide patient safety as evidenced by: * Five of five nursing staff and one of one physician were unable to access and utilize medications and supplies for pediatric emergencies in a safe and timely manner. * Failure to ensure supplies necessary to administer medications during a pediatric emergency were available on one of two pediatric crash carts. * Failure to ensure the nursing medication administration record accurately reflected discontinued medications and that this was identified by pharmacists during their clinical rounds. * Failure to ensure involvement and oversight by pharmacy on the storage and safe use of pediatric emergency medications. 1. On 7/24/07 at 1401 hours, in the pediatric urgent care unit the pediatric physician (referred to now as Physician 5) was asked if (s)he ran the pediatric codes (code pinks) in the emergency	A 252		

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A 252	Continued From page 57 department (ED) and the pediatric outpatient care unit. Physician 5 said (s)he would run the pediatric codes (code pink) in ED and in the pediatric outpatient care unit. On 7/24/07, during the same interview, Physician 5 was asked what source did (s)he use for dosing pediatric patients during a pediatric code. Physician 5 said it was the Broselow tape. Broselow system is a commercial product designed for management of pediatric emergencies. The Broselow tape facilitates determination of medication dosages and equipment sizes for children, by measuring the child against the length of the tape. The Broselow tape is sectioned into color zones that correspond to a pediatric weight range. For example, the " green " zone corresponds to a weight range of 30 kilograms (kgs) to 36 kgs. Physician 5 said (s)he would call out the drug and dose with the expectation that the nurse would remove the drug and draw up the dose. On 7/24/07 at 1402 hours, Physician 5 was asked if one of the nurses on the pediatric outpatient care unit (three nurses standing in front of the physician and the surveyor) would help run the pediatric code. Physician 5 said yes. On 7/24/07 at 1402 hours, the surveyor approached one of the three nurses and asked who would run the pediatric code. One of the nurses (referred to as RN 1) said that (s)he would be the one who would run the pediatric code with the physician. On 7/24/07 at 1407 hours, RN 1 was asked to pull and show the drug including any associated equipment that would be used to administer the	A 252		

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A 252	Continued From page 58 dose. RN 1 was asked to provide a dose of 3.3 mg (3.3 ml) of epinephrine 1:1000. This was based on " green " zone or the 30 to 36 kilogram weight from the Broselow tape. On 7/24/07 at 1410 hours, RN 1 provided the surveyor with a vial of epinephrine 1:1000. RN 1 required the help of two other Nurses (RN 2 and RN 3) which took 3 minutes and 15 seconds to find the vial of epinephrine 1:1000. RN 1 was asked how (s)he would draw up the dose of epinephrine 1:1000 since it was in a vial. RN 1, 2 and 3 looked in the pediatric crash cart drawers and could not find a syringe where upon RN 1 asked one of the nurses (RN 2 and RN 3) to get some syringes. RN 1 took another 25 seconds to obtain a syringe that would be used to draw up the epinephrine 1:1000 for administration. On 7/24/07 at 1414 hours, RN 1 was asked pull and show the drug that would be used to provide a dose of atropine 0.5 mg or 5.0 mls based on the " green " zone or 30 to 36 kilograms on the Broselow tape. RN 1 took 1 minute and 10 seconds to find and present the atropine. On 7/24/07 at 1422 hours, RN 1 was asked how (s)he would compound dopamine and dobutamine to provide a standard concentration for infusion based on the Broselow tape. RN 1 said (s)he would use the Broselow tape and proceeded to review the Broselow tape and indicated it was not listed on the Broselow tape. Review of the Broselow tape stated the following on medication guidance for infusions: " Pursuant to JCAHO ' s (Joint Commission for Accreditation	A 252		

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

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A 252	Continued From page 59 of Healthcare Organizations) National Patient Safety Goals 3b ' Rule of 6 ' for infusions should be converted to Standardized Concentrations " . On 7/24/07 at 1422 hours, Physician 5 was asked what were the standard concentrations (s)he would expect the nurse to compound for dopamine and dobutamine. Physician 5 said that dobutamine or dopamine would not be used right away so (s)he would have time to look it up. On 7/24/07 during the same interview, Physician 5 was asked what (s)he would use to look up the standardized concentration. Physician 5 said (s)he would use her/his PDA (personal digital assistant) to look up the dosing. On 7/24/07, Physician 5 was asked to see the information on his/her PDA. Physician 5 replied that (s)he would use a prescription book and promptly went into another room. Physician 5 came out with a piece of paper and was asked again what were the standard concentrations (s)he would ask the nurse to compound for dopamine and dobutamine. On 7/24/07 during the same interview Physician 5 said that the dobutamine would be 2 - 20 mcg/kg/min and the dopamine would be 2 - 20 mcg/kg/min. On 7/24/07, during the same interview the surveyor showed each vial of dopamine and dobutamine (from the pediatric medication tray) to Physician 5 and asked Physician 5 what concentration or standardized concentration would the physician want to compound for or what was the standard concentration for dobutamine and dopamine to be used to compound each drug. On 7/24/07 at 1423, Physician 5 said that the dopamine was 2-20 mcg/kg/min and dobutamine was 2-20 mcg/kg/min.	A 252		

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A 252	Continued From page 60 Physician 5 gave a dosage range of what was to be infused but failed to provide the standard concentration (s)he would have had the nurse compound for a dopamine and dobutamine infusion. Review of the pediatric dosing chart on 7/24/07, located in the emergency room identified the standardized concentration of dopamine is 1.6 mg/ml. The standardized concentration of dobutamine is 1 mg/ml. This information was not available in the pediatric urgent care unit. Failure of the physician to instruct the nurse on how to quickly mix the solutions of dopamine and/or dobutamine could result in the nurse having to guess at the amounts to mix and a delay in administering the drugs while calculating the dosage range ordered by the physician. The following issues were identified regarding provision of medical, nursing and pharmaceutical care for medical management of pediatric codes: (a) RN 1 was unfamiliar with the contents of the pediatric emergency medication supply resulting in delayed retrieval of medications (epinephrine and atropine). (b) The necessary equipment was not present to administer medications as evidenced by the lack of syringes in the pediatric crash cart. (c) Both the physician and the nurse were unable to demonstrate or provide guidance on how to compound a standardized concentration of dopamine and dobutamine, according to the pediatric dosing chart utilized by the hospital, for infusion during a pediatric code. This did not ensure accurate and timely administration of these drugs during an emergency situation.	A 252		

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A 252	Continued From page 61 2. On 7/24/07 at 1550 hours, an emergency room nurse (referred to as RN 5) was asked if (s)he would be the nurse who would respond to a pediatric code (code pink) and pull and draw up medications for a pediatric code. On 7/24/07, during the same interview Nurse 5 said (s)he would be the nurse. On 7/24/07 at 1550 hours, RN 5 was asked to provide the drug and any associated supplies for the following drugs based on the " green " zone of the Broselow tape (34 kg to 36 kg) for epinephrine 1:1000 3.3 mg (3.3 ml) and atropine 0.50 mg (5.0 ml). On 7/24/07 at 1551 hours, RN 5 was asked to provide the dose of epinephrine 1:1000 at 3.3 mg or 3.3 ml. On 7/24/07 during the same interview (45 seconds later) RN 5 stated " don't have it would use a calculator to calculate the amount " , which was based on converting 1:10,000 of epinephrine (s)he found to 1:1,000. On 7/24/07 after the RN made the previous statement (s)he looked again into the pediatric crash cart where the medications were located and found the epinephrine 1:1000 vial and handed the vial and a 5 ml syringe to the surveyor. On 7/24/07 at 1553 hours, RN 5 was asked how (s)he would compound dopamine and dobutamine to provide a standard concentration for infusion. On 7/24/07, RN 5 during the same interview said that the pediatric crash cart should have them premixed as in the other hospital she worked at and proceeded to look for the premixed dopamine and dobutamine. On 7/24/07 at 1558 hours, RN 5 could not find the	A 252		

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A 252	Continued From page 62 premixed dopamine and dobutamine but found vials of dobutamine 250 mg per 20 ml and dopamine 200 mg per 5 ml. On 7/24/07 during the same interview RN 5, was asked how (s)he would compound the dopamine and dobutamine. RN 5 said (s)he she would use the pediatric dosing chart which for dopamine was 1.6 mg per ml and the dobutamine was 1 mg/ml. On 7/24/07 at 1558 hours, RN 5 was asked how (s)he would compound either drug to provide the standard concentration for dobutamine and dopamine based on the pediatric dosing chart. On 7/24/07, during the same interview RN 5 said that based on how the premixed solutions from the other hospital (s)he worked at she would put 40 mls of dobutamine 250 mgs per 20 mls in 500 mags of solution and 400mgs of dopamine (10 mls) in 500 mls of solution. The following issues were identified: (a) When dopamine 200 mgs per 5 mls is compounded to 400mgs in a 500 mls bag the calculated amount of dopamine is 400mgs per 510 mls which would provide a concentration of 0.78 mg per ml which would not be the same as the required 1.6 mg/ml. (b) When dobutamine 250 mgs per 20 mls is compounded to 500 mgs per 40 mls to a 500 mls bag the calculated amount of dobutamine is 500 mgs per 520 mls which would be 0.93 mg per ml which is not the same as the required 1 mg/ml (c) RN 5 was unfamiliar and not knowledgeable	A 252		

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A 252	Continued From page 63 about which medications were available in the pediatric emergency medication tray located in the pediatric crash cart as evidenced by his/her inability to locate epinephrine 1:1000 and belief that dopamine and dobutamine were available as " pre-mixed " intravenous solutions. 3. On 07/26/07 at 1234 hours, in the pediatric outpatient clinic RN 1 and RN 4 were asked to remove drugs and draw up doses of medications found in the pediatric crash cart for a mock pediatric code. RN 4 would be the nurse who would remove the drugs and draw the dose and RN 1 would be the nurse transcribing the events. On 07/26/07 at 1234, RN 4 was asked to remove the drug and draw up a dose of 0.27 mg of epinephrine 1:10,000. RN 4 and RN 1 said that they would require that the dose be in milliliters (mls) not mgs because that was they way they were taught. On 07/26/07, during the same interview, the surveyor said to provide 2.7 mls epinephrine 1:10,000. On 07/26/07 at 1242, RN 4 was asked to draw up dextrose 13.3 grams. RN 4 and RN 1 said that the dose should be requested as mls, to which the surveyor replied that 13.3 grams is what is listed on the Broselow tape and there were no mls listed. On 07/26/07, during the same interview RN 4 asked the surveyor which dextrose was to be used for the dose to which the surveyor replied " which one do you have? " RN 4 showed a box of 25% dextrose (2.5 g per 10 ml) Min-I-Jet prefilled syringe to which the surveyor replied 13.3 grams of dextrose was needed.	A 252		

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A 252	Continued From page 64 RN 4 was observed to use a separate 10 ml syringe to withdraw the dextrose from the prefilled vial. RN 4 was asked why that methodology was done. RN 4 said that " that was the way we were taught " . The Min-I-Jet prefilled syringe system has a vial of dextrose which fits into an injector needle so there would be no need for transferring dextrose from one syringe to another. The unit assembles quickly by placing the vial into an injector needle, which is rotated to lock it in and it is ready to administer. It took three minutes for RN 4 to withdraw 10 mls of dextrose from the pre-filled vial. It was brought to the attention of RN 4 that the Min-I-Jet system is a ready to use system and that it was unnecessary for him/her to withdraw the dextrose but to simply assemble the Min-I-Jet system. Following this direction RN 4 then assembled the Min-I-Jet system and prepared 10 mls of dextrose or 2.5 grams of the requested dose within eight seconds. The following issues were identified: (a) During the pediatric mock code RN 1 and RN 4 said they were taught to use milliliters. The majority of doses listed on the Broselow tape are given in milligrams or grams (38 of 42 drugs listed). The drugs that list the dose as milliliters list both milliliters and milligrams (mgs) and have the mgs listed first. (b) During the mock pediatric code RN 4 was asked which dextrose was to be used when the dose was given in grams. RN 4 was holding in	A 252		

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A 252	Continued From page 65 her hand Dextrose 25% and did not have any other strength. The dose was given in grams because that was how it was listed on the Broselow tape and this allows the dose to be accurately administered since there is no confusion of over the number of mls to be administer in the event that a different strength is utilized (e.g. dextrose 50%). RN 4 by asking which dextrose was to be used when RN 4 had only one strength in her/his hand, demonstrated that RN 4 was unfamiliar and not knowledgeable about the medications in the pediatric drug tray located in the pediatric crash cart. (c) RN 4 demonstrated (s)he was unfamiliar with how to assemble and use prefilled syringes. 4. On 7/24/07 at 1507 hours, Pharmacist 1, Pharmacist 2 and Pharmacist 3 were asked how did the pharmacy educate and ensure that the pediatric outpatient unit and the emergency department used drugs safely and effectively during a pediatric code situation (code pink). On 7/24/07, during the same interview Pharmacist 1, Pharmacist 2, and Pharmacist 3 failed to provide evidence that pharmacy educated and ensured that staff safely and effectively used drugs during a pediatric code situation. On 7/27/07 at 1050 hours, Pharmacist 1, Pharmacist 2 and Pharmacist 3 were interviewed whether they were aware of mock pediatric codes " Code Pink Drill " conducted by hospital staff. All three pharmacists were unaware there was mock pediatric code and were unaware if medications were even used in the mock pediatric code.	A 252		

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A 252	Continued From page 66 A mock code pink was performed by the hospital on 6/14/07. Review of the Mock Code Blue Skills Sheet Checklist (used for the code pink drill), on 7/27/07 at 0800, had the following assessments regarding use of medications: (a) assemble prefilled syringe correctly - ' not applicable ' (b) identifies items and respective locations in the crash cart - ' not applicable ' The hospital conducted a mock pediatric code more than a month prior to the survey that failed to assess staff ' s ability to identify and prepare medications for use during a pediatric emergent situation (e.g. code pink) in that the assessment is listed as " not applicable " . During the survey hospital staff (RN 5, RN 1, RN 4 and Physician 5) failed to: identify medications (e.g. epinephrine, dopamine and dobutamine), demonstrate ability to compound infusions for dopamine and dobutamine and prepare medications in accordance with manufacturer ' s guidelines (e.g. Dextrose pre-filled syringe). The pharmacy was not involved or aware of staff ' s ability to effectively and safely use equipment and medications during a pediatric emergent situation (e.g. code pink) 5. On 07/26/07 at 1242 hours, RN 4 was asked to draw up dextrose 13.3 grams for a pediatric patient in the " orange " zone or 24 -28 kilogram weight range on the Broselow tape with the stipulated condition that the pediatric patient had a blood glucose of 50 mg/dl. A normal blood glucose range is 70 to 110 mg/dl and a level of 50 is considered hypoglycemic or evidence of a low	A 252		

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A 252	Continued From page 67 blood sugar. RN 1 was present during the interview of RN 4. On 07/26/07, RN 1 questioned the surveyor as to why dextrose was used because the dextrose was for an " overdose " . On 07/26/07, during the same interview, the surveyor responded that it was being used for low blood glucose. On 07/26/07, RN 1 during the same interview, pointed to the part of the Broselow tape that listed dextrose under the heading of " overdose " , and said dextrose was used only for overdose. On 07/26/07, during the same interview, the surveyor told RN 1 that the dextrose was being used for low blood sugar. The following issue was identified: Pointing out on the Broselow tape that dextrose was used only for " overdose " demonstrated that RN 1 was unfamiliar with the pediatric drugs in the drug tray that would be used in conjunction with the Broselow tape. Prior to the dextrose dose being requested the clinical condition of the patient was provided to both RN 1 and RN 4 (patient had blood glucose of 50 mg/dl and needed dextrose to increase blood glucose levels). The American Hospital Formulary Service (published 2004) medication reference has dextrose listed as a carbohydrate caloric agent and dextrose injections are frequently used in adults and children to restore blood glucose concentrations in treatment of hypoglycemia resulting from insulin excess or other causes. 10-25% dextrose injections are used in neonates and infants to restore blood glucose concentrations in the treatment of symptomatic	A 252		

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A 252	Continued From page 68 hypoglycemia. 6. On 7/27/07 at 0815 hours, the medical record for Patient #77 was reviewed. Patient #77 had a physician order, written on 6/27/07 at 1500, for " droperidol 0.625 mg IV (intravenous) Q 6 H (every six hours) prn (as needed) N/V (nausea and vomiting) " . On 7/27/07 at 0820 hours, a review of the medication administration records (MAR) dated 06/27/07 and 06/28/07, had " DROPERIDOL INJ Dose: 0.625 MG IVP Give: 0.25 ml of 2.5 MG per 1 ML IVP Q 6 H PRN N/V " as an active order for both days. On 7/27/07 at 0840 hours, Pharmacist 1 and Pharmacist 2 were asked if the physician order was clarified since droperidol has a blackbox warning (see warning next paragraph). Pharmacist 2 said the order was clarified by a pharmacist and it was discontinued. The issue was that the droperidol was an " active " order on the MAR since there was no line through it or "discontinue" written for that drug as per policy and procedure entitled " Medication Administration " . Droperidol (Inapsine) has a black box warning from the manufacturer stating that, " cases of QT prolongation and/or torsades de pointes have been reported in patients receiving Inapsine (droperidol) at doses at or below recommended doses. Some cases have occurred in patients with no known risk factors for QT prolongation and some cases have been fatal. " Torsades de Pointes is a cardiac arrhythmia, which may cause blackouts or sudden death.	A 252		

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A 252	Continued From page 69 The black box warning for droperidol stipulates; " due to its potential for serious proarrhythmic effects and death, Inapsine (droperidol) should be reserved for use in the treatment of patients who fail to show an acceptable response to other adequate treatments. " Pharmacist 1 failed to demonstrate that the pharmacists performing clinical rounds identified that there was an active order for a medication that should have been discontinued and was still available for possible administration by nursing staff.	A 252		
A 278	482.26(d)(1) AUTHENTICATED RADIOLOGY REPORTS The radiologist or other practitioner who performs radiology services must sign reports of his or her interpretations. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, the hospital failed to ensure that the radiologist who performed the radiology services signed reports of the interpretations in one closed record reviewed. Findings: The medical record of Patient #104 was reviewed on 7/26/07 at 1500 hours. The chest x-ray done on 7/7/07 was " Dictated By " one radiologist and " Electronically Signed By " a different radiologist. On 7/27/07 at 0900 hours, Staff MD-X was interviewed. He stated that when reports are electronically signed by a different radiologist, that radiologist actually reviews the films to compare with the dictated interpretation. This expected	A 278		

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A 278	Continued From page 70 practice was not written in policy or stated on the final radiology report.	A 278		
A 299	482.28(a)(3) COMPETENT DIETARY STAFF There must be administrative and technical personnel competent in their respective duties. This STANDARD is not met as evidenced by: Based on observation, staff interview, and dietary P &P (policy and procedure) reviews, the hospital failed to ensure that dietary personnel were competent in their respective duties. Findings: 1. During the kitchen observation at 1100 hours on 7/23/07, the sanitizing solutions in two areas , used for sanitizing food contact areas, were not at an effective level: a. It was observed that there were red buckets filled with sanitizing solution and cleaning cloths. The Food Service Manager (FSM) stated, "My staff fill these buckets at the beginning of the day's shift and they should be refilled with solution every two hours throughout the day. It is spot checked periodically. But we don't keep logs and I don't know when it was tested last." The FSM was asked to check the concentration of the sanitizing solution in a bucket which was half full of slightly soiled water. The chemical test strip did not change color nor measure that the solution had any sanitizer in it. The manufacturer's instructions on the sanitizer indicated the effective level was 150-400 parts per million for effective sanitizing.	A 299		

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A 299	Continued From page 71 b. There was a half full spray bottle of sanitizing solution which was also tested and found to be less than 100 ppm or at an ineffective level. The FSM stated that they used the spray bottles until the solution was gone before refilling. He acknowledged that his staff did not test or monitor the solution for effectiveness. The hospital's P & P titled, Required Cleaning and Sanitization, stated "To prevent cross-contamination, kitchenware and food-contact surfaces of equipment shall be washed, rinsed, and sanitized after each use...Where equipment and utensils are used for the preparation of potentially hazardous foods on a continuous or production-line basis, utensils and the food-contact surfaces of equipment shall be washed, rinsed, and sanitized...Follow manufacturer's instructions for solution preparation. Change the solution as often as necessary, when it becomes dirty. Although (name of the sanitizing solution) does not dissipate, its effectiveness is impaired by organic soil in the solution." The P & P titled, Sanitizing Food Contact Surfaces stated the following: Each work area shall be equipped with sanitizing solution. Most cloths used for wiping food spills on food-contact surfaces shall be cleaned and rinsed frequently in a sanitizing solution used for no other purpose. These cloths shall be stored in the sanitizing solution between uses. If using sanitizer in red buckets, these procedures must be followed: Replace sanitizer solution in buckets every 2 hours and whenever visibly dirty. If using sanitizer in spray bottles, these procedures must be followed: Replace sanitizer solution in spray bottles every day.	A 299		

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A 299	Continued From page 72 Sanitizer test strips should be readily available wherever sanitizer is placed. Complete Sanitizer Solution Concentration Log once a day for sanitizer being dispensed from unit. The FSM acknowledged that they could not depend upon monitoring the concentration of the dispenser unit, but needed to monitor the effectiveness of the solutions (in buckets and in spray bottles) in use. 2. At 0900 on 7/24/07, a cook was observed opening large #10 cans. The food contents became exposed to the outside of the lid as it was opened. There had been no observation of the cook cleaning or sanitizing the top of the can lids prior to opening the cans. When asked, the cook stated, "I have this (dry) cloth here, attached to my belt, and I wipe the can lids in the store room before bringing them into the prep area." The FSM stated that he would have expected the cleaning and sanitizing of can lids, but they did not have a specific P & P for this. 3. At 1000 on 7/25/07, the following were identified during the review of the small kitchen pantry on level 4B: a. The charge nurse stated that her staff washed the can lids of enteral formula with water from the faucet. She stated that they did not have a sanitizing solution and had never been instructed to clean and sanitize the can lids prior to pouring them into the open enteral feeding bags. The Director of Food & Nutrition Services (DFNS) acknowledged that they needed to ensure that the can lids were sanitized and free of any contaminants from transport and the vendor	A 299		

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A 299	Continued From page 73 warehouse. The DFNS stated that she was unaware of a P & P for sanitizing can lids for enteral formula. b. The FSM stated that his staff rotated the resident's stock in the pantry's refrigerator, but nursing staff were responsible for cleaning the refrigerator. The charge nurse stated that it was their practice to wash the inside of the refrigerator with hand soap from the hand sink. She stated that they did not have a written P & P for this. It was observed that there was a lack of detergent and sanitizing solution available in the pantry. The FSM acknowledged that there was a lack of training and monitoring to ensure that the refrigerator was cleaned according to standards used in the main kitchen.	A 299		
A 317	482.41 PHYSICAL ENVIRONMENT 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, interview and record review, the hospital failed to maintain equipment, supplies and the building in a manner to ensure the safety of patients. Findings: 1. The hospital failed to ensure the building was maintained in a manner to meet NFPA 101 Life Safety Code Standards. Refer to A321. 2. The hospital failed to maintain equipment and	A 317		

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A 317	Continued From page 74 supplies to ensure acceptable levels of quality and safety. Refer to A331. The cumulative effect of these systemic practices resulted in the failure of the hospital to deliver statutorily mandated compliance with the Condition of Participation: Physical Environment CFR 482.41.	A 317		
A 321	482.41(b) LIFE SAFETY FROM FIRE The hospital must ensure that specific life safety from fire requirements are met. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the hospital failed to ensure life safety from fire requirements were met. Findings: 1. The hospital failed to ensure the building was maintained without penetrations in ceilings and smoke barrier walls. Refer to K 012 of the Life Safety Code Survey. 2. The hospital failed to maintain the magnetic devices and closure latches for all smoke barrier doors. Refer to K 021 and K 027 of the Life Safety Code Survey. 3. The hospital failed to ensure all smoke barrier walls were not penetrated. Refer to K 025 of the Life Safety Code Survey. 4. The hospital failed to maintain the fire alarm system annunciation and illumination devices in operational status. Refer to K 052 of the Life Safety Code Survey.	A 321		

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A 321	Continued From page 75 5. The hospital failed to ensure maintenance, inspection and testing of the fire sprinkler system was completed as required by NFPA 13 and NFPA 25. Refer to K 062 of the Life Safety Code Survey. 6. The hospital failed to provide a UL 300 rated fire suppression system in two of three kitchen areas. Refer to K 069 of the Life Safety Code Survey. 7. The hospital failed to ensure the safe storage of oxygen cylinders. Refer to K 076 of the Life Safety Code Survey.	A 321		
A 331	482.41(c)(2) FACILITIES, SUPPLIES, & EQUIP 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 observation, the facility failed to ensure supplies in the emergency room area were maintained in a manner to ensure patient safety. Findings: 1. At 1000 hours on 7/24/07, the Chief Executive Officer reported an incident to the survey team. Patient #54 was able to obtain a sharp object and cut themselves while in the emergency room during the early morning hours of 7/24/07. On 7/24/07 the incident was investigated.	A 331		

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A 331	Continued From page 76 The patient's medical record showed that at approximately 0400 hours Patient #54 was observed through the window of the room door, cutting both arms with a scalpel. The nurse documented the patient got the scalpel from a bag of Dorito chips. The lot number on the packaging of the scalpel used by the patient was the same as the lot number of others observed by surveyors stored in the locked supply area of the emergency room. Hospital documents show staff were aware of this on 7/26/07. On 7/26/07 at approximately 1030 hours, in the emergency room triage area a cart was observed next to the gurney that had open drawers. Inside the drawers were dressing supplies needles, laboratory specimen tubes and and scalpels. A patient was seated in front of the cart. Staff were not monitoring this area for patient safety. At 0930 hours on 7/27/07, the same cart was observed with open drawers and a patient sitting in the chair in front of it. Next to the patient's chair was a small rolling cart. On the top of the cart was a sharp surgical clamp. On the bottom shelf of the cart was a basin with scissors in it. This area was not being supervised by the staff in the triage area. 2. The hospital failed to ensure the safe cleaning and storage of endoscopes and also failed to ensure adequate air exchanges in negative pressure rooms. Cross refer to A339. 3. The hospital failed to ensure appropriate sterization procedures for equipment used during surgical procedures. Cross refer to A342.	A 331		
A 338	482.42 INFECTION CONTROL	A 338		

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A 338	Continued From page 77 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, and failed to ensure there was an active infection control program for the prevention, control, and investigation of infections and communicable diseases. Findings: 1. The hospital failed to ensure that policies and procedures were developed and implemented that governed the control of infections and communicable diseases. Refer to A 339. 2. The hospital failed to develop a system for identifying, reporting, investigating, and controlling infections. Refer to A 340. 3. The hospital failed to develop a log of incidents related to infections and communicable diseases in the hospital. Refer to A 341. 4. The hospital failed to ensure that the hospital wide quality assurance program and training programs addressed problems identified by the infection control officer. Refer to A 342. The cumulative effect of these systemic practices	A 338		

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A 338	Continued From page 78 resulted in the failure of the hospital to deliver statutorily mandated compliance with the Condition of Participation: Infection Control, CFR §482.42.	A 338		
A 339	482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the hospital failed to ensure that the infection control officer developed and implemented policies and procedures governing control of infections and communicable diseases. Findings: 1. The hospital failed to develop and implement policies and procedures for the cleaning and storage of flexible endoscopes (instruments that touch mucous membranes or non-intact skin) consistent with their established policy and manufacturer's guidance. The hospital's 7/20/07 policy and procedure for the cleaning and sterilization of endoscopic equipment was reviewed. The policy and procedure directed that endoscopes were to be leak tested after the initial cleaning according to manufacturer's recommendations. The policy and procedure also directed that the endoscopes were to be stored hanging in a vertical position, to facilitate drying in an appropriate storage cabinet. A review of manufacturer's guidance for flexible endoscopes used in the hospital directed that the	A 339		

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A 339	Continued From page 79 endoscopes were to be leak tested after pre-cleaning, brushes were to be used to clean all accessible channels, components / surfaces, and the last step was to rinse all internal channels and the external scope surfaces with alcohol. The manufacturer's also directed that the flexible endoscopes be hung for storage, keeping the insertion tube as straight as possible, in a well ventilated dust free cabinet. On 7/24/07 at 1530 hours, the pulmonary department was toured. During a concurrent interview hospital staff stated that currently the hospital had one bronchoscope. A request was made for hospital staff to discuss the process for cleaning and storage of flexible endoscopes. Hospital staff explained the cleaning process and stated that after cleaning, the endoscope was stored in a covered tray. The covered tray on top of the bronchoscopy was inspected and a coiled flexible endoscope was observed inside. When asked if the endoscope could be stored by hanging, hospital staff replied, "yes." Hospital staff was then asked to identify the location where the flexible endoscope would be stored hanging. Hospital staff identified a wooden coat rack inside a storage room as the location where the endoscope would be hung. Hospital staff was asked if leak testing and flushing the flexible endoscope with alcohol was part of the cleaning process, hospital staff stated she did not know about leak testing, but because of a previous incident, containers of alcohol were not available at the hospital. On 7/24/07 at 1610 hours, the gastrointestinal lab	A 339		

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A 339	Continued From page 80 was toured. When interviewed about their cleaning of flexible fiberoptic endoscopes, hospital staff stated that the flexible endoscopes were leak tested and flushed with alcohol at the end of the cleaning process. Containers of ethyl alcohol were observed in a cabinet where the flexible endoscopes were cleaned. During a concurrent interview, hospital staff stated that the alcohol was purchased through materials management. On 7/24/07, 7/25/07 and 7/26/07, three additional areas (surgery, anesthesia, and surgical clinic), where flexible endoscopes were cleaned and stored were toured. During confidential interviews it was determined that personnel in the three areas did not clean and store flexible endoscopes according to manufacture's guidance. The three areas did not perform leak testing or flush the flexible endoscopes with alcohol as directed by the manufacturer. After cleaning, the surgical clinic's flexible endoscopes, were stored in an open area. During an interview on 7/26/07 at 1400 hours, hospital staff verified that four of the five areas, where flexible endoscopes were cleaned and stored, were not following hospital policy and manufacturer's guidance. 2. There was a delay of several months before the hospital acted on the recommendation to change from using "smoke tubes" to monitoring the number of air exchanges when assessing the negative pressure in a patient room.	A 339		

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A 339	Continued From page 81 On 7/24/07 at 1012 hours, the emergency department was toured. An inspection of the entrance doors of the isolations rooms disclosed a form used to verify that rooms had negative pressure. The measurement on the form listed "Pass / fail" indicating the presence or absence of negative pressure. On 7/25/07 at 1100 hours, hospital staff was interviewed about what "pass / fail" meant. Hospital staff stated that prior to 5/07 the hospital used smoke tubes to check the air balance in the negative pressure rooms. Hospital staff stated that the negative pressure monitoring tool posted on the room doors was obsolete since the smoke test was no longer used. Hospital staff stated that currently, the number of air exchanges was used to evaluate the negative pressure status. Hospital staff stated that that they had determined that each negative pressure room would have a minimum of 10 air exchanges per hour. The documentation of the hospital's negative pressure rooms monitoring for 6/07 was reviewed. The documentation showed that one room (5b -17) had 9.1 air exchanges per hour. During an interview on 7/26/07 at 1400 hours, hospital staff stated that sometime last year the recommendation was made to switch from using the smoke test to monitoring the number of air exchanges as a means of evaluating the presence of negative pressure. Hospital staff stated that the request was, "lost in the shuffle." 3. The hospital failed to develop a policy and procedure to ensure that a closed system was maintained during hemodialysis reducing the	A 339		

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A 339	Continued From page 82 incidence of patient exposure to infectious diseases. On 7/27/07 at 0955 hours, the hemodialysis clinic was toured. It was noted that a patient was receiving hemodialysis at that time. It was noted that the dialysis access was a catheter in the patient's left chest. Inspection of the hemodialysis machine showed a red connector going into the dialysate (chemical solution that takes the wastes and extra fluids trapped by the dialyzer and carries them away from the blood) during dialysis. It was noted that the red connector was sitting in the gallon bottle and the dialysate solution was exposed to air. It was also noted that the solution that had previously been exposed to patient's blood was stored in a closed system container. During a concurrent interview hospital staff was asked about the dialysate solution being exposed to air. Hospital staff stated that the connector was used to "suck up" the solution. Hospital staff also stated that if, "If something falls into the solution we throw it away." On 7/27/07 at 1050 hours, additional hospital staff was interviewed about the dialysate and that there was a possibility of exposing patients to infectious diseases when the dialysate was exposed to air. Hospital staff stated that they did not have a policy or procedure related to maintaining a closed system during dialysis. Hospital staff also stated that adapters were available that would ensure a closed system was maintained during hemodialysis.	A 339		
A 340	482.42(a)(1) RESPONSIBILITIES OF IC OFFICER(S)	A 340		

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A 340	Continued From page 83 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 hospital failed to develop a system for identifying, reporting, investigating, and controlling infections. Findings: 1. The hospital did not have a process in place for the identification of patients who may have been exposed to an infectious disease. On 7/24/07, Patient #10's medical record was reviewed. Documentation in the medical record showed that on 7/16/07, the patient was scheduled for a bronchoscopy. A procedure note written on 7/16/07 at 1450 hours, documented that the patient had consented for a "FOB (fiberoptic bronchoscopy) but there was problem with either the light source or the scope. No light seen from end of scope." The physician decided to intubate (place an artificial airway) and use endotracheal suction to try and clear the right lung. On 7/24/07 at 1100 hours, the GI (gastrointestinal) patient log was reviewed. The log showed that the endoscope that was to be	A 340		

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A 340	Continued From page 84 used for Patient #10's bronchoscopy on 7/16/07 was cleaned the following day on 7/17/07. The patient log also identified that the bronchoscope used for Patient #10's procedure was P-302413208. During an interview on 7/24/07 at 1255 hours, hospital staff stated that the bronchoscope that was to be used for Patient #10's procedure was cleaned by sterile processing on 7/18/07. Hospital staff stated that usually one brush is used to clean a bronchoscope, however, three brushes were used to clean bronchoscope P-302413208. Hospital staff also stated that "a lot" of black substance was removed from inside the bronchoscope during the cleaning process. Hospital staff stated that bronchoscope P-302413208 was in use until 7/19/07. On 7/25/07 at 1500 hours, a request was made to obtain a list of patients who had bronchoscopes in the intensive care unit. Hospital staff identified Patient #41 as having had a bronchoscopy. Patient #41's medical record was reviewed. Documentation in the medical record showed that the patient had a bronchoscopy at 1600 hours on 7/17/07. Documentation in the medical record also showed that the patient was being treated for active tuberculosis. On 7/25/07 the GI patient log was again reviewed. It was noted the GI patient log did not indicate Patient #41 had a bronchoscopy on 7/17/07. During an interview on 7/26/07 at 1500 hours, hospital staff stated they did not have a process	A 340		

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A 340	Continued From page 85 or policy for identifying patients who had possibly been exposed to contagious diseases or patients who had a bronchoscopy. Hospital staff also stated that she was unaware that the bronchoscope P-30-2413208 had been used for Patient #41's bronchoscopy on 7/17/07. 2. The hospital did not develop a system for reporting infection and communicable disease data. On 7/27/07 at 0955 hours, the hemodialysis clinic was toured. During the tour hospital staff stated that samples for dialysate and water cultures (culture showing the integrity of the dialysate solution) were taken every month for each dialysis machine. The dialysate and water culture report for 2007 was reviewed. The report showed that three times dialysis machine #4 had the failed dialysate and water culture standards, and that dialysis machines # 2 and #3 had each failed the dialysate and water culture standards once. During an interview on 7/27/07 at 1050 hours, hospital staff stated that infection control staff were notified when the dialysate and water cultures did not meet pre set standards. Hospital staff also stated that historically the infection control data was not communicated outside the infection control department. 3. The hospital failed to develop a system for identifying, and controlling infections and communicable diseases for all patients served at the hospital. On 7/26/07 at 1400 hours, the hospital infection control plan and the infection control surveillance data for 2007 were reviewed. During the review it	A 340		

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A 340	Continued From page 86 was noted that the infection control plan and the surveillance data contained no evidence that specific infection control plans had been developed for the 11 outpatient clinics. During an interview on 7/27/07 at 1050 hours, hospital staff verified that no clinic specific infection control plans had been developed. As a result, the infection control issues were not being reported to the QAPI committee nor was the medical staff or governing body being informed.	A 340		
A 341	482.42(a)(2) INFECTION CONTROL LOG The infection control officer or officers must maintain a log of incidents related to infections and communicable diseases. This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to ensure that a log of incidents related to infections and communicable diseases was maintained by the hospital. Findings: On 7/26/07 the hospital wide infection control plan was reviewed. It was noted that no infection control plans had been developed for hospital clinics. The hospital was noted to have the following clinics; Surgical (genitourinary), Dialysis, Pediatric, Dental, Obstetrics and Gynecology, and Oasis (where patients with human immunodeficiency virus) are seen. During an interview on 7/26/07 at 1500 hours, hospital staff stated the hospital wide infection control plan was based on the national patient safety goals with additional direction from the Los	A 341		

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A 341	Continued From page 87 Angeles Department of Health Services. Hospital staff stated that individual infection control plans had not been developed for the hospital's clinics. When asked how incidents related to infections and communicable diseases in the clinics would be tracked, hospital staff stated that the clinic staff would need to notify the infection control department.	A 341		
A 342	482.42(b) LEADERSHIP RESPONSIBILITIES The chief executive officer, the medical staff, and the director of nursing must ensure that the hospital-wide quality assurance program and training programs address problems identified by the infection control officer or officers; and be responsible for the implementation of successful corrective action plans in affected problem areas. This STANDARD is not met as evidenced by: Based on observation, interview and document review, hospital leadership failed to ensure, that the hospital wide quality assurance program and training programs addressed problems identified by the infection control officer, and that hospital leadership was responsible for implementation of successful corrective action plans. Findings: 1. On 7/26/07 at 1500 hours, hospital staff was interviewed regarding the hospital quality assessment and performance improvement (QAPI) program. Hospital staff were also asked about how staff in-services and training programs addressed problems identified by the infection control program. Hospital staff stated the infection	A 342		

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A 342	Continued From page 88 control indicators were based on the national patient safety goals with additional direction from the Los Angeles Department of Health Services. Hospital staff stated that a hospital wide assessment for infection control needs by department had not been done. Hospital staff also stated that they were unclear about what the educational or training needs of the hospital staff were. Hospital staff were unable to provide examples of problem areas identified by the hospital related to the infection control program. It was noted that during the interview hospital staff verbalized problem areas that had been cited during previous Federal surveys. 2. On 7/24/07 at 1530 hours, concerns regarding the cleaning practices of flexible endoscopes (instruments that touch mucous membranes or non-intact skin) were identified. At that time, hospital staff stated that the identified practice of cleaning the flexible endoscopes had been going on for years. During an interview on 7/24/07 at 1525 hours, hospital staff stated that there had been no formal training for physicians, and hospital staff that cleaned and stored the flexible endoscopes. 3. During an interview on 7/24/07 at 1255 hours, hospital staff were interviewed regarding the hospital's flash sterilizing practice. Hospital staff stated that through the month of 6/07, staff responsible for processing equipment in the operating room were flash sterilizing at least once a day.	A 342		

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A 342	Continued From page 89 During a tour of the sterile processing area a portable cart, approximately 3 to 4 feet in length, with three shelves was observed. It was noted that all three cart shelves were filled with clean, but unsterile instruments. A request was made for a list of the number of surgical cases and a listing showing the number of times instruments were flash sterilized in the operating room. The two documents were reviewed, compared and they showed that instruments used to maintain a patient's airway were flash sterilized over 56 percent of the time. In addition, the list showed that instruments such as various types of forceps, scissors, clamps were also routinely flash sterilized. During interviews on 7/25/07 at 1230 hours, hospital staff stated that before a sterile processing consultant left the organization in 9/06, she had discussed the issue of flash sterilization in the operating room. Hospital staff stated that from 9/06 until 3/07 flash sterilization was not monitored by hospital staff. Hospital staff stated, "We are working on it," when asked if the operating room staff had been in-serviced and trained about the routine practice of flash sterilizing instruments. Flash sterilization is the process by which surgical instruments are sterilized for immediate use should an emergency situation arise. For example; to sterilize an instrument that was accidentally dropped. Flash sterilization is not intended to replace conventional steam sterilization of surgical instruments or to reduce the need for adequate instrument inventory. A 6/1/06 article in "Infection Control Today,"	A 342		

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A 342	Continued From page 90 directed that the new recommended practice from AORN (Association of periOperative Registered Nurse) on sterilization, specifically states, "flash sterilization should not be used as a substitute for insufficient instrumentation." 4. On 7/25/07 at 1000 hours, the sterilizer used to sterilize biohazard waste was inspected. During the inspection hospital staff stated that the sterilizer takes about one and half hours to sterilize a load of biohazard waste. Hospital staff also stated that the sterilizer runs 24 hours a day, 7 days a week. During an interview on 7/26/07 at 1500 hours, hospital staff were asked about the volume of biohazard waste generated at the facility. Hospital staff stated that the majority of biohazard waste was generated in the emergency department. When questioned if the waste was actually biohazard waste, hospital staff replied, "No." When asked about education or in-service training programs, hospital staff stated that the in-service programs have "been ineffective."	A 342		
A 371	482.45(a)(1) OPO AGREEMENT The written protocols must incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the hospital, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye	A 371		

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A 371	Continued From page 91 banks identified by the hospital for this purpose; This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to develop written protocols for incorporation with their organ procurement organization (OPO) agreement. Findings: On 7/23/07 at 1400 hours, the intensive care patient log was reviewed. Documentation in the log showed that patients had been referred to the OPO. On 7/24/07 documentation provided by the hospital, showed that in the first quarter of 2007 there was one patient accepted as an organ donor. Additional documentation provided by the hospital and reviewed on 7/26/07 showed that 75 percent of the time the hospital notified the OPO timely. During an interview on on 7/26/07 at 1700 hours, hospital staff stated they did not have a policy that identified the specific time frame for notifying the OPO.	A 371		
A 388	482.51(a)(3) OR CIRCULATING NURSES Qualified registered nurses may perform circulating duties in the operating room. In accordance with applicable State laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately	A 388		

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

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A 388	Continued From page 92 available to respond to emergencies. This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to ensure registered nurses were qualified to perform circulating duties in the operating room. Findings: On 7/26/07 at 0950 hours, an inspection of the room in the surgical clinic where surgical procedures (cystostomy/cystoscopy) were performed, was conducted. The cystoscopy log was reviewed and it showed that on 3/27/07, two cystoscopies were performed. During a concurrent interview, a hospital employee verified that she was the circulating nurse that day. The hospital employee, a nurse manger over the area, stated that she was not a circulating registered nurse. The nurse stated that the circulating nurse assigned to the surgical clinic was on vacation. The nurse manager stated she was just filling in and was "there to sign the papers."	A 388		
A 390	482.51(b) OR POLICIES 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. This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to ensure high standards for patient care provided in the surgical clinic.	A 390		

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A 390	Continued From page 93 Findings: 1. On 7/26/07 at 0950 hours, the operating room in the surgical clinic was toured. During the tour a hospital employee verified that she did not have clinical competencies to be a circulating nurse. The hospital employee also verified that the day (3/27/07) she was the the circulating nurse she was, "there to sign the papers." 2. During the tour it was also noted that the process for cleaning and storing flexible endoscopes (instruments that touch mucous membranes or non-intact skin) was inconsistent with the hospitals approved policy. The hospital was unable to provide documentation showing that hospital staff working in the surgical clinic, who cleaned the flexible endoscopes, had been trained prior to 7/23/07.	A 390		
A 395	482.51(b)(5) OR REGISTER The operating room register must be complete and up to date. This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to ensure that the operating log was complete and up to date. Findings: 1. On 7/26/07 at 0950 hours, an inspection of the room in the surgical clinic where surgical procedures (cystostomy/cystoscopy) are performed was conducted. The cystoscopy room (operating room) log was reviewed. It was noted that documentation in the	A 395		

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A 395	Continued From page 94 log was incomplete. On 3/27/07 documentation showed that a patient had a spinal for a cystostomy. The log did not indicate who the anesthesiologist was. In 7/07 it was noted that the name of the surgeon was not indicated. During a concurrent interview hospital staff verified that the operating room log was incomplete. 2. On 7/26/07 at 1500 hours, an inspection of the dental and oral maxillofacial clinic was conducted. Staff identified there was a preoperative/postoperative area and three operating rooms. There were anesthesia carts in the rooms. The operating room log was reviewed. Documentation in the log was incomplete. The log did not indicate who the anesthesiologist was. It did not identify the type of anesthesia given. Staff interviews revealed local anesthesia and local anesthesia with conscious sedation was used in the operating rooms.	A 395		
A 431	482.53(a)(2) POLICIES The qualifications, training, functions and responsibilities of the nuclear medicine personnel must be specified by the service director and approved by the medical staff. This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to document that the qualifications, training, functions and responsibilities of nuclear medicine personnel were specified by the service director and approved by the medical staff. Findings:	A 431		

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A 431	Continued From page 95 On 7/25/07 at 1410 hours, the nuclear medicine and radiological supervisors and directors (Chief of Radiology, Medical Director of Nuclear Medicine, Chief Radiological Technologist and Interim Supervising Nuclear Medicine Technologist) were interviewed and department records reviewed. During this interview it was noted that the department had both a " Los Angeles County Class Specification " and a hospital "Position Description," for the nuclear medicine personnel. However, none of these documents were signed by, or otherwise authenticated, by any medical staff members or current hospital employee. Nor could the interviewed radiology and nuclear medicine supervisory staff provide any other evidence that the qualifications, training, functions and responsibilities of nuclear medicine personnel had been specified by the nuclear medicine director, Chief of Radiology, or any medical staff members.	A 431		
A 447	482.54(a) INTEGRATION OF OUTPATIENT SERVICES Outpatient services must be appropriately organized and integrated with inpatient services. This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to ensure that outpatient services were integrated with inpatient services. Findings: 1. During interviews on 7/26/07 at 1415 hours, hospital staff stated that a needs quality assessment performance improvement (QAPI) assessment had been completed on approximately 40 percent of the inpatient	A 447		

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A 447	Continued From page 96 departments. During a second interview on 7/27/07 at 0845 hours, hospital staff stated that essentially no out-patient services had been assessed. 2. On 7/26/07 at 0950 hours, the operating room in the surgical clinic was toured. During the tour a hospital employee verified that she did not have clinical competencies to be a circulating nurse in the operating room. The hospital employee also verified that the day (3/27/07) she was the the circulating nurse, she was, "There to sign the papers." 3. On 7/26/07 from 1440 hours to 1635 hours, a tour of the dental clinic was conducted with hospital staff. One of the oral and maxillofacial surgeons stated that the clinic was a part of the dedicated emergency department where patients could present during business hours for emergency services and have a medical screening exam. Review of the emergency room central log for 6/29/07 failed to reveal evidence that any patients from the "Oral and Maxillofacial Surgery Clinic Log - Unscheduled Patients" were logged and identified as emergency room patients and/or counted in the emergency room visit log. Three of the patients on the clinic log were identified as "urgent" and one was identified as having a left facial cellulitis. 4. On 7/27/07 at 0955 hours, the hemodialysis clinic was toured. During the tour hospital staff stated that samples for dialysate and water cultures (culture showing the integrity of the dialysate solution) were taken every month for	A 447		

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A 447	Continued From page 97 each dialysis machine. The dialysate and water culture report for 2007 was reviewed. The report showed that three times dialysis machine #4 had the failed dialysate and water culture standards, and that dialysis machines # 2 and #3 had each failed the dialysate and water culture standards once. During an interview on 7/27/07 at 1050 hours, hospital staff stated that infection control staff were notified when the dialysate and water cultures did not meet pre set standards. Hospital staff also stated that historically the infection control data was not communicated outside the infection control department. 5. The hospital failed to develop a system for identifying, and controlling infections and communicable diseases for patients receiving outpatient services. On 7/26/07 at 1400 hours, the hospital infection control plan and the infection control surveillance data for 2007 were reviewed. During the review it was noted that the infection control plan and the surveillance data contained no evidence that specific infection control plans had been developed for the 11 outpatient clinics. During an interview on 7/27/07 at 1050 hours, hospital staff verified that no clinic specific infection control plans had been developed. As a result, outpatient services were not integrated into the QAPI program of the hospital.	A 447		
A 448	482.54(b) OUTPATIENT SERVICES PERSONNEL The hospital must assign an individual to be responsible for outpatient services; and have appropriate professional and nonprofessional personnel available.	A 448		

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A 448	Continued From page 98 This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to assign a manager to the outpatient hemodialysis clinic. Findings: 1. On 7/27/07 at 0955 hours, the hemodialysis clinic was toured. It was noted that a patient was receiving hemodialysis at that time. It was also noted that a red connector going into the dialysate solution (chemical solution that takes the wastes and extra fluids trapped by the dialyzer and carries them away from the blood) was loose and the dialysate solution was exposed to air. During an interview on 7/27/07 at 1050 hours, hospital staff stated that she was not aware of what was going on the hemodialysis clinic. Hospital staff stated that there had not been a manager for the hemodialysis clinic for about one year. The manager would have been responsible for correcting infection control issues and for reporting those issues to the QAPI committee. 2. On 7/26/07 at 1400 hours, the hospital infection control plan and the infection control surveillance data for 2007 were reviewed. During the review it was noted that the infection control plan and the surveillance data contained no evidence that specific infection control plans had been developed for the 11 outpatient clinics. During an interview on 7/27/07 at 1050 hours, hospital staff verified that no clinic specific infection control plans had been developed. As a	A 448		

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A 448	Continued From page 99 result, the infection control issues were not being reported to the QAPI committee nor was the medical staff or governing body being informed.	A 448		
A 452	482.55 EMERGENCY SERVICES The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based on observation, interviews, document review and medical record reviews, the hospital failed to meet the emergency needs of patients in accordance with acceptable standards of practice. 1. The hospital failed to ensure that all emergency services were under the direction of the emergency services medical staff. Refer to A 0454. 2. The hospital failed to ensure medical and nursing personnel were adequate in numbers and qualifications to meet the written procedures and needs anticipated by the hospital. Refer to A 0459. The cumulative effect of these systemic practices resulted in the failure of the hospital to deliver statutorily mandated compliance with the Condition of Participation: Emergency Services, CFR§482.55.	A 452		
A 454	482.55(a)(1) ORGANIZATION OF EMERGENCY SERVICES The services must be organized under the direction of a qualified member of the medical staff.	A 454		

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A 454	Continued From page 100 This STANDARD is not met as evidenced by: Based on observations, interviews and document reviews, the hospital failed to ensure all emergency services were organized under the direction of qualified emergency services medical staff. Findings: 1. On 7/23/07 an observational tour of the emergency service areas was conducted. Interviews conducted with staff members identified that emergency services included the main emergency room (ER), adult urgent care and the pediatric urgent care. Patients would present to the main emergency area where the patients would be assessed/triaged by a nurse for appropriate category. Patients assessed as category I, II or III identified as having more serious injuries or illnesses were to be seen and treated in the main ER, while patients assessed as category IV or V would be treated in either the adult urgent care or pediatric urgent care (PUC) based on age. The staff did not identify the dental or oral and maxillofacial clinic as a place the emergency room patients were sent after triage for a medical screening examination. On 7/26/07 from 1440 hours to 1635 hours, a tour of the dental clinic was conducted with hospital staff. One of the oral and maxillofacial surgeons stated that the clinic was a part of the dedicated emergency department where patients could present during business hours for emergency services and have a medical screening exam. If the patient presented with dental or facial pain at the main emergency room during clinic hours, they were escorted to the dental clinic for their medical screening evaluation. EMTALA signage	A 454		

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A 454	Continued From page 101 was observed posted in the lobby and in all treatment rooms. However, the surgeon stated the Department of Surgery of the medical staff had oversight of the clinic. Review of the emergency room central log for 6/29/07, failed to reveal evidence that any patients from the "Oral and Maxillofacial Surgery Clinic Log - Unscheduled Patients" were logged and identified as emergency room patients and/or counted in the emergency room visit log. Three of the patients on the clinic log were identified as "urgent" and one was identified as having a left facial cellulitis.	A 454		
A 459	482.55(b)(2) QUALIFIED PERSONNEL There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility. This STANDARD is not met as evidenced by: Based on document, personnel file and medical record reviews, interviews and observation, the facility failed to ensure adequate numbers of qualified nursing personnel to meet the needs of patients in the emergency department (ED). Findings: 1. On 7/24/07, Emergency Department Policy and Procedure #118 for Management of Psychiatric Patients stated that: * Patient's clothing and valuables must be secured, interventions initiated timely and sitter needs identified. * The RN assigns a sitter to the patient who	A 459		

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A 459	Continued From page 102 documents patient behavior and interventions hourly. * At no time should the patient be left alone. *The licensed nurse documents on the nursing assessment the assigned sitter's name * The sitter's name is written on the Emergency Room Shift Assignment Sheet. The hospital failed to ensure this policy for patient safety was implemented as follows: At 1000 hours on 7/24/07, the Chief Executive Officer reported an incident to the survey team. Patient #54 was able to obtain a sharp object and cut themselves while in the emergency room during the early morning hours of 7/24/07. On 7/24/07 the incident was investigated. At 1035 hours Patient #54 was observed walking with staff. The staff stated they were taking the patient for a shower. The patient was observed to have thin tape-like dressings on each lower arm measuring approximately 3 inches long. The skin around the dressings was a normal color. At 1145 hours Patient #54 was interviewed. The patient related frustration with the hospital staff because they would not listen to attempts, to inform them of prior treatment received, for the condition being treated 7/24/07. The patient stated this led to the incident of cutting both arms. The patient refused to say where the sharp object used for the cuts was originally obtained, but stated that it was taken out of a bag of chips, to inflict the cuts. During the interview, the patient's personal belongings were observed at the bedside. The patient stated no one looked in the belongings bag prior to the incident and there was no staff assigned to sit in her room. The patient	A 459		

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A 459	Continued From page 103 stated the door to the room might have been closed at the time of the cutting incident. At 1205 hours staff stated they had left Patient #54 in the shower room unattended to allow for patient privacy. There was no visualization of the patient to ensure safety. A review of nurse staffing for the emergency room for the early morning hours of 7/24/07 revealed there were more than three patients in the emergency room requiring "sitters." Only 3 sitters were assigned to the emergency room. Staff interviews revealed a staff member was not assigned to sit with Patient #54. Staff stated there was no policy and procedure for "sitter" duties and a job description for the position was only recently developed. Administrative staff stated that employee files might or might not have evidence that the sitters were aware of their duties when assigned the job of "sitter." A review of the medical record showed Patient #54 was in the emergency room on 7/23/07 with thoughts of suicide with pills. There was no documentation if the patient brought personal belongings with them and/or their disposition. The patient was transferred to another facility at approximately 2300 hours. Approximately 2 hours later, at 0115 hours on 7/24/07, the patient was brought back to the emergency room with a different chief complaint. The same nurse was assigned to care for the patient and documented that the patient had thoughts of suicide with pills. There was no documentation if the patient brought personal belongings with them and/or their disposition. There was no documented evidence a sitter was assigned to watch the patient on a 1:1 basis.	A 459		

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A 459	Continued From page 104 At approximately 0330 hours the patient was found, by nursing, outside the emergency room smoking. Safety police were with the patient. Patient #54 was brought back to the emergency room. At approximately 0400 hours Patient #54 was observed through the window of the room door, cutting both arms with a scalpel. The nurse documented the patient got the scalpel from a bag of Dorito chips. The lot number on the packaging of the scalpel used by the patient was the same as the lot number of others observed, by surveyor, stored in the locked supply area of the emergency room. On 7/24/07 at approximately 1550 hours, observations of patients identified as a danger to themselves were made in the emergency room. Patient #56 was observed with 3 suitcases at the bedside. A handbag was on the bed with the patient. These belongings had not been secured. Patient # 50 was observed to have a bag of belongings at the head of the gurney. There was a sitter at the bedside. Patient #50 was observed to walk to the bathroom with a bag of personal belongings and close the door. The door was locked. The sitter stood outside the door. The patient was in the bathroom approximately 5 minutes. Observation of the bathroom revealed glass mirrors and nurse call cords that the patient could have accessed. Interview with one "sitter" at 1045 hours on 7/26/07, revealed the employee was in-serviced the night before regarding his duties as a sitter and use of the new observation form for documentation. Personnel files reviewed on 7/27/07 revealed two of two "sitter's" files failed to	A 459		

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A 459	Continued From page 105 contain documented evidence that the employees were informed of their duties as a sitter, prior to 7/24/07. 2. On 7/23/07 an observational tour of the emergency service areas was conducted. Interviews conducted with staff members identified that emergency services included the main emergency room (ER), adult urgent care and the pediatric urgent care. Patients would present to the main emergency area where the patients would be assessed/triaged by a nurse for appropriate category. Patients assessed as category I, II or III identified as having more serious injuries or illnesses were to be seen and treated in the main ER, while patients assessed as category IV or V would be treated in either the adult urgent care or pediatric urgent care (PUC) based on age. Interviews conducted with PUC nursing staff members revealed that patients from newborn to 17 1/2 (teenagers) years of age received treatment in their service area. Patients seen and treated in the PUC were either directed from main ER or were seen for follow-up of an emergency condition that had been previously treated in the ER. Pediatric patients that required routine clinic care or scheduled appointments received care in an outpatient pediatric clinic. The unit was observed to have two crash/code carts. One cart was a pediatric crash cart and the other was an adult crash cart. Review of the hospital policy titled, Code Pink, reviewed and revised in July 2007, identified that a Code Pink Team responded to all Code Pink pages. The policy identified that the code pink team was made up of a PALS (pediatric	A 459		

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A 459	Continued From page 106 advanced life support) certified pediatric physician, an ACLS (advanced cardiac life support) certified anesthesiologist, an ACLS and PALS certified ER nurse and a respiratory therapist. The Code Pink team members were required to carry code pagers. Interviews conducted with pediatric urgent care nursing staff and the director of nursing clarified that the ER nurse, identified in the policy, was a pediatric urgent care nurse. Pediatric Advance Life Support (PALS) is a course that is designed to provide caregivers with skills, which would enable them to both recognize the potential for respiratory and/or cardiac arrest in infants and children and to intervene in an effective and efficient manner, resulting in improved outcomes. Advanced Cardiac Life Support (ACLS) is a course that is designed to provide caregivers with skills that would enable them to both recognize the potential for respiratory and/or cardiac arrest in adult patients and to intervene in an effective and efficient manner, resulting in improved outcomes. Interviews were conducted with the ER nursing director, the pediatric nurse manager and the physician chair of pediatrics at 1100 hours on 7/26/07 to clarify the relationship of the PUC to emergency services. It was explained that pediatric patients referred from the main ER would receive medical screening examinations in the PUC. Per interviews, the PUC, was a dedicated part of emergency services. The job description for a registered nurse working	A 459		

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A 459	Continued From page 107 in the PUC described that the following credentials were required; RN license, BLS (basic life support), PALS, and ACLS. Personnel files were reviewed for four registered nurses (RN 1, RN 2, RN 3 and RN 4) identified as working in the PUC. Four of the four nurses reviewed failed to have ACLS certification. On 7/27/07 a follow up conversation was conducted with the nurse manager of the PUC. The issue of the ACLS requirement for the registered nurses working in the pediatric urgent care was discussed. The nurse manager stated that the requirement to have ACLS certification, as defined in the job description, was a typo (error). Further discussion failed to provide evidence as to how the PUC nurses would be deemed competent to provide life saving measures, including the administration of emergency medications, to adult sized teenagers. 3. On 7/26/07 at 1234 hours, in the pediatric outpatient clinic RN 1 and RN 4 were asked to remove drugs and draw up doses of medications found in the pediatric crash cart for a mock pediatric code. RN 4 would be the nurse who would remove the drugs and draw the dose and RN 1 would be the nurse transcribing the events. On 7/26/07 at 1234, RN 4 was asked to remove the drug and draw up a dose of 0.27 mg of epinephrine 1:10,000. RN 4 and RN 1 said that they would require that the dose be in milliliters (mls) not mgs because that was they way they were taught. On 7/26/07, during the same interview, the surveyor said to provide 2.7 mls epinephrine 1:10,000.	A 459		

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A 459	Continued From page 108 On 7/26/07 at 1242, RN 4 was asked to draw up dextrose 13.3 grams. RN 4 and RN 1 said that the dose should be requested as mls, to which the surveyor replied that 13.3 grams is what is listed on the Broselow tape and there were no mls listed. On 7/26/07, during the same interview RN 4 asked the surveyor which dextrose was to be used for the dose to which the surveyor replied " which one do you have? " RN 4 showed a box of 25% dextrose (2.5 g per 10 ml) Min-I-Jet prefilled syringe to which the surveyor replied 13.3 grams of dextrose was needed. RN 4 was observed to use a separate 10 ml syringe to withdraw the dextrose from the prefilled vial. RN 4 was asked why that methodology was done. RN 4 said that " that was the way we were taught " . The Min-I-Jet prefilled syringe system has a vial of dextrose which fits into an injector needle so there would be no need for transferring dextrose from one syringe to another. The unit assembles quickly by placing the vial into an injector needle, which is rotated to lock it in and it is ready to administer. It took three minutes for RN 4 to withdraw 10 mls of dextrose from the pre-filled vial. It was brought to the attention of RN 4 that the Min-I-Jet system is a ready to use system and that it was unnecessary for him/her to withdraw the dextrose but to simply assemble the Min-I-Jet system. Following this direction RN 4 then assembled the Min-I-Jet system and prepared 10 mls of dextrose or 2.5 grams of the requested dose within eight	A 459		

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A 459	Continued From page 109 seconds. The following issues were identified: (a) During the pediatric mock code RN 1 and RN 4 said they were taught to use milliliters. The majority of doses listed on the Broselow tape are given in milligrams or grams (38 of 42 drugs listed). The drugs that list the dose as milliliters list both milliliters and milligrams (mgs) and have the mgs listed first. (b) During the mock pediatric code RN 4 was asked which dextrose was to be used when the dose was given in grams. RN 4 was holding in her hand Dextrose 25% and did not have any other strength. The dose was given in grams because that was how it was listed on the Broselow tape and this allows the dose to be accurately administered since there is no confusion of over the number of mls to be administer in the event that a different strength is utilized (e.g. dextrose 50%). RN 4 by asking which dextrose was to be used when RN 4 had only one strength in her/his hand, demonstrated that RN 4 was unfamiliar and not knowledgeable about the medications in the pediatric drug tray located in the pediatric crash cart. (c) RN 4 demonstrated (s)he was unfamiliar with how to assemble and use prefilled syringes. 4. On 7/24/07 at 1550 hours, an emergency room nurse (referred to as Nurse 5) was asked if (s)he would be the nurse who would respond to a pediatric code (code pink) and pull and draw up medications for a pediatric code. On 07/24/07, during the same interview Nurse 5 said (s)he would be the nurse.	A 459		

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A 459	Continued From page 110 On 7/24/07 at 1550 hours, RN 5 was asked to provide the drug and any associated supplies for the following drugs based on the " green " zone of the Broselow tape (34 kg to 36 kg) for epinephrine 1:1000 3.3 mg (3.3 ml) and atropine 0.50 mg (5.0 ml). On 7/24/07 at 1551 hours, RN 5 was asked to provide the dose of epinephrine 1:1000 at 3.3 mg or 3.3 ml. On 7/24/07 during the same interview (45 seconds later) RN 5 stated " don't have it would use a calculator to calculate the amount " , which was based on converting 1:10,000 of epinephrine (s)he found to 1:1,000. On 7/24/07 after the RN made the previous statement (s)he looked again into the pediatric crash cart where the medications were located and found the epinephrine 1:1000 vial and handed the vial and a 5 ml syringe to the surveyor. On 7/24/07 at 1553 hours, RN 5 was asked how (s)he would compound dopamine and dobutamine to provide a standard concentration for infusion. On 7/24/07, RN 5 during the same interview said that the pediatric crash cart should have them premixed as in the other hospital she worked at and proceeded to look for the premixed dopamine and dobutamine. On 7/24/07 at 1558 hours, RN 5 could not find the premixed dopamine and dobutamine but found vials of dobutamine 250 mg per 20 ml and dopamine 200 mg per 5 ml. On 7/24/07 during the same interview RN 5, was asked how (s)he would compound the dopamine and dobutamine. RN 5 said (s)he she would use the pediatric dosing chart which for dopamine	A 459		

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A 459	Continued From page 111 was 1.6 mg per ml and the dobutamine was 1 mg/ml. On 7/24/07 at 1558 hours, RN 5 was asked how (s)he would compound either drug to provide the standard concentration for dobutamine and dopamine based on the pediatric dosing chart. On 7/24/07, during the same interview RN 5 said that based on how the premixed solutions from the other hospital (s)he worked at she would put 40 mls of dobutamine 250 mgs per 20 mls in 500 mags of solution and 400mgs of dopamine (10 mls) in 500 mls of solution. The following issues were identified: (a) When dopamine 200 mgs per 5 mls is compounded to 400mgs in a 500 mls bag the calculated amount of dopamine is 400mgs per 510 mls which would provide a concentration of 0.78 mg per ml which would not be the same as the required 1.6 mg/ml. (b) When dobutamine 250 mgs per 20 mls is compounded to 500 mgs per 40 mls to a 500 mls bag the calculated amount of dobutamine is 500 mgs per 520 mls which would be 0.93 mg per ml which is not the same as the required 1 mg/ml (c) RN 5 was unfamiliar and not knowledgeable about which medications were available in the pediatric emergency medication tray located in the pediatric crash cart as evidenced by his/her inability to locate epinephrine 1:1000 and belief that dopamine and dobutamine were available as " pre-mixed " intravenous solutions. 5. On 7/24/07 at 1401 hours, in the pediatric	A 459		

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A 459	Continued From page 112 urgent care unit the pediatric physician (referred to now as Physician 5) was asked if (s)he ran the pediatric codes (code pinks) in the emergency department (ED) and the pediatric outpatient care unit. Physician 5 said (s)he would run the pediatric codes (code pink) in ED and in the pediatric outpatient care unit. On 7/24/07, during the same interview, Physician 5 was asked what source did (s)he use for dosing pediatric patients during a pediatric code. Physician 5 said it was the Broselow tape. Broselow system is a commercial product designed for management of pediatric emergencies. The Broselow tape facilitates determination of medication dosages and equipment sizes for children, by measuring the child against the length of the tape. The Broselow tape is sectioned into color zones that correspond to a pediatric weight range. For example, the " green " zone corresponds to a weight range of 30 kilograms (kgs) to 36 kgs. Physician 5 said (s)he would call out the drug and dose with the expectation that the nurse would remove the drug and draw up the dose. On 7/24/07 at 1402 hours, Physician 5 was asked if one of the nurses on the pediatric outpatient care unit (three nurses standing in front of the physician and the surveyor) would help run the pediatric code. Physician 5 said yes. On 7/24/07 at 1402 hours, the surveyor approached one of the three nurses and asked who would run the pediatric code. One of the nurses (referred to as RN 1) said that (s)he would be the one who would run the pediatric code with the physician.	A 459		

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A 459	Continued From page 113 On 7/24/07 at 1402 hours, the surveyor asked RN 1 to demonstrate how the nurse would convert the defibrillator for use with the pediatric paddles. RN 1 took 2 minutes and 10 seconds to try to " plug ' in the paddles and when (s)he was done showed the paddles to the surveyor and indicated they were ready. On 7/24/07 during the same interview, the surveyor ask if the paddles were pediatric paddles; RN 1 took 30 seconds with the help from two other nurses (RN 2 and RN 3) to find and provide the pediatric defibrillator/monitoring pads that would be used with the defibrillator. The paddles originally shown to the surveyor where adult paddles not those used for pediatric patients. It took RN 1 with the help of two other RNs (RN 2 and RN 3) a total of two minutes and 40 seconds to produce the correct pediatric defibrillator/monitoring pads. On 7/24/07 at 1407 hours, RN 1 was asked to pull and show the drug including any associated equipment that would be used to administer the dose. RN 1 was asked to provide a dose of 3.3 mg (3.3 ml) of epinephrine 1:1000. This was based on " green " zone or the 30 to 36 kilogram weight from the Broselow tape. On 7/24/07 at 1410 hours, RN 1 provided the surveyor with a vial of epinephrine 1:1000. RN 1 required the help of two other Nurses (RN 2 and RN 3) which took 3 minutes and 15 seconds to find the vial of epinephrine 1:1000. RN 1 was asked how (s)he would draw up the dose of epinephrine 1:1000 since it was in a vial.	A 459		

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A 459	Continued From page 114 RN 1, 2 and 3 looked in the pediatric crash cart drawers and could not find a syringe where upon RN 1 asked one of the nurses (RN 2 and RN 3) to get some syringes. RN 1 took another 25 seconds to obtain a syringe that would be used to draw up the epinephrine 1:1000 for administration. On 7/24/07 at 1414 hours, RN 1 was asked pull and show the drug that would be used to provide a dose of atropine 0.5 mg or 5.0 mls based on the " green " zone or 30 to 36 kilograms on the Broselow tape. RN 1 took 1 minute and 10 seconds to find and present the atropine. On 7/24/07 at 1422 hours, RN 1 was asked how (s)he would compound dopamine and dobutamine to provide a standard concentration for infusion based on the Broselow tape. RN 1 said (s)he would use the Broselow tape and proceeded to review the Broselow tape and indicated it was not listed on the Broselow tape. Review of the Broselow tape stated the following on medication guidance for infusions: " Pursuant to JCAHO ' s (Joint Commission for Accreditation of Healthcare Organizations) National Patient Safety Goals 3b ' Rule of 6 ' for infusions should be converted to Standardized Concentrations " . On 7/24/07 at 1422 hours, Physician 5 was asked what were the standard concentrations (s)he would expect the nurse to compound for dopamine and dobutamine. Physician 5 said that dobutamine or dopamine would not be used right away so (s)he would have time to look it up. On 7/24/07 during the same interview, Physician 5 was asked what (s)he would use to look up the	A 459		

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

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A 459	Continued From page 115 standardized concentration. Physician 5 said (s)he would use her/his PDA (personal digital assistant) to look up the dosing. On 7/24/07, Physician 5 was asked to see the information on his/her PDA. Physician 5 replied that (s)he would use a prescription book and promptly went into another room. Physician 5 came out with a piece of paper and was asked again what were the standard concentrations (s)he would ask the nurse to compound for dopamine and dobutamine. On 7/24/07 during the same interview Physician 5 said that the dobutamine would be 2 - 20 mcg/kg/min and the dopamine would be 2 - 20 mcg/kg/min. On 7/27/07, during the same interview the surveyor showed each vial of dopamine and dobutamine (from the pediatric medication tray) to Physician 5 and asked Physician 5 what concentration or standardized concentration would the physician want to compound for or what was the standard concentration for dobutamine and dopamine to be used to compound each drug. On 7/24/07 at 1423, Physician 5 said that the dopamine was 2-20 mcg/kg/min and dobutamine was 2-20 mcg/kg/min. Physician 5 gave a dosage range of what was to be infused but failed to provide the standard concentration (s)he would have had the nurse compound for a dopamine and dobutamine infusion. The following issues were identified regarding provision of medical, nursing and pharmaceutical care for medical management of pediatric codes: (a) RN 1 was unfamiliar with how to locate, connect and utilize pediatric defibrillator pads or paddles.	A 459		

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A 459	Continued From page 116 (b) RN 1 was unfamiliar with the contents of the pediatric emergency medication supply resulting in delayed retrieval of medications (epinephrine and atropine). (c) The necessary equipment was not present to administer medications as evidenced by the lack of syringes in the pediatric crash cart. (d) Both the physician and the nurse were unable to demonstrate or provide guidance on how to compound a standardized concentration of dopamine and dobutamine for infusion during a pediatric code. 6. Review of two Code Pink drills (a practice session in which a scenario involving a child is used to practice emergency responses) revealed that there was no documentation that the anesthesiologist on call had responded to the Code Pink page. The Code Pink drills are called in to the hospital operator in the same manner as other codes. The operator then pages the individuals who are on-call, including anesthesia. In addition the code is announced overhead. On 3/22/07 a Code Pink drill was called at 1130 hours in the Family Birth Center. The drill leader identified as an issue with the drill that the anesthesiologist indicated his Code Pink pager	A 459		

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A 459	Continued From page 117 didn't alarm. On 6/14/07 at 0945 hours a Code Pink drill was conducted in the pediatric outpatient area. For this drill there was a sign-in sheet, however there was no documentation that an anesthesiologist had responded to the emergency page. In an interview on 7/27/07 at 1005 hours the Chairman of the Department of Anesthesiology stated he was unable to provide any documentation as to who was carrying the Code Pink pagers at the time of the Code Pink drills or what problem there was with the pagers that may have prevented the anesthesiologist on call from responding to the Code Pink page.	A 459		
A 473	482.57(a)(1) DIRECTOR OF RESPIRATORY SERVICES There must be a director of respiratory care services who is a doctor of medicine or osteopathy with the knowledge, experience and capabilities to supervise and administer the service properly. The director may serve on either a full-time or part-time basis. This STANDARD is not met as evidenced by: Based on observation and interview, the hospital leadership failed to ensure the proper administration of respiratory services . Findings: On 7/24/05 at 1725 hours, the respiratory department was toured. The door open to the hallway was unlocked and that no respiratory department staff were observed in the department. It was also noted that the door leading to the blood gas machine was unlocked. A blood gas machine, analyzes a blood sample to determine a patient's respiratory status.	A 473		

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A 473	Continued From page 118 During an interview on 7/25/07 at 1000 hours, hospital staff verified that the doors leading to the blood gas machine were never locked. Hospital staff also verified that visitors and non respiratory personnel could access the blood gas machine, and that the blood gas machine was not always secured.	A 473		
A 476	482.57(b)(2) PERSONNEL POLICIES Personnel qualified to perform specific procedures and the amount of supervision required for personnel to carry out specific procedures must be designated in writing. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the hospital failed to ensure that personnel were qualified to carry out specific procedures. Findings: On 7/24/07 at 1530 hours, the pulmonary department during was toured. During the tour a covered tray, on top of the bronchoscopy, was observed with coiled flexible endoscope (instruments that touch mucous membranes or non-intact skin) inside. During an interview on 7/26/07 at 1400 hours, hospital staff verified that prior to 7/18/07, there was no evidence to demonstrate competency for the respiratory staff who cleaned the flexible endoscopes. Hospital staff also stated that the practice of how the flexible endoscopes were cleaned had been going on for years.	A 476		
A1008	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible.	A1008		

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A1008	Continued From page 119 This STANDARD is not met as evidenced by: Based on medical record review, nursing staff failed to ensure that legible documentation was entered into the chart of Patient #47. Findings: Patient #47 presented to the emergency room on 7/22/07 at 1400 hours, with a chief complaint of dizziness and "heart fast." Review of the physician order sheet revealed that a medication was circled on the form, which indicted that the medication was not given. To the right of the order on the form was six lines of nursing documentation that could not be deciphered and or read. Review of the the patient's record revealed a form utilized by the ER for the recording of medication administration and allowed for the recording of the patient's response to the medication. The form was noted to have six medication entries and response entries. The penmanship style of the nurse recording the information, resulted in the entries being illegible. Nursing notes dated and timed from 1410 hours to 1510 hours based on the same penmanship were difficult to read.	A1008		
A1009	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be complete.	A1009		

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A1009	Continued From page 120 This STANDARD is not met as evidenced by: Based on medical record and document review and staff interviews, the hospital failed to ensure medical record entries were complete in two closed records and in two open records. Findings: 1. The medical record for Patient #10 was reviewed on 7/24/07. It showed an admission date of 7/19/07. The record contained six consent forms for procedures. Three of the six consent forms were incomplete. The consent for a thoracentesis did not contain the name of the physician to perform the procedure or a written description of the risks versus benefits of the procedure. Documentation of this conversation was contained in the physician progress notes; however, the form did not identify them. A consent form for the percutaneous insertion of a central catheter failed to contain the date and time the physician signed the form. A consent form for anesthesia did not contain the name of the anesthesiologist that would perform the procedure. 2. At 1230 hours on 7/24/07, the medical record for Patient #54 contained a Patient Transfer Summary and Acknowledgement form. There was a signature in the space for patient acknowledging the transfer. The form contained a "witness" signature by the hospital staff. Areas for information regarding diagnosis, treatment, condition, receiving facility, "transfer checklist," and "physician certification" were blank. 3. The medical record of Patient #103 was reviewed on 7/26/07 at 1445 hours. The transcribed history and physical report contained	A1009		

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A1009	Continued From page 121 the heading: "Date of Admission," however, no date was entered. On the morning of 7/27/07 at 1000 hours, Staff HIM-A confirmed that this information was missing and that it should have been recorded by either the transcription staff or by the physician when the report was signed. This closed record (#103) was considered "complete" by the hospital. 4. The medical record of Patient #111 was reviewed on 7/27/07 at 1045 hours. The transcribed consultation report contained a blank line to indicate the name of a medication could not be understood by the transcriptionist. The physician had signed the report without filling-in the missing information. This closed record (#111) was considered "complete" by the hospital.	A1009		
A1011	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, the hospital failed to ensure that all entries were authenticated consistent with hospital policy in one closed record. Findings: The medical record of Patient #101 was reviewed on 7/26/07 at 1140 hours. There were two nursing progress notes written on 4/27/07 which were authenticated only with the initials " KF " . There was no corresponding signature legend on the form to identify the author and document the full signature. Interview with	A1011		

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A1011	Continued From page 122 Staff HIM-A on the morning of 7/27/07 revealed that medical entries are expected to be signed using at least the first initial, full last name, and discipline	A1011		
A1023	482.52(b)(3) ANESTHESIA SERVICES With respect to inpatients, a post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia as specified in paragraph (a) of this section within 48 hours after surgery. This STANDARD is not met as evidenced by: Based on interview with facility staff and review of documents the facility failed to ensure that a post-anesthesia evaluation was completed and documented by an individual qualified to administer anesthesia within 48 hours after surgery. One of eight medical records for patients who received anesthesia did not contain a post-anesthesia evaluation. Findings: Review of the medical record for Patient #98 revealed he presented to the emergency department on 7/17/07 at 2138 hours. He was complaining of right lower quadrant pain since that morning. He was seen by the emergency room physician at 2215 hours. A surgical consultation was obtained at 0028 hours on 7/18/07 and a diagnosis of acute appendicitis was made. An abbreviated medical history and physical examination for a 48-hour admission was completed and the patient was admitted to the hospital. The patient was consented for an appendectomy at 0125 hours. At 0305 hours the patient was taken to the operating room where he	A1023		

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A1023	Continued From page 123 underwent an appendectomy under general anesthesia. An initial post-operative anesthesia evaluation was written immediately after the case at 0455 hours. The patient was then taken to the post-anesthesia recovery room where he remained until 1530 hours when he was sent to his room. On 7/19/07 at 0713 hours the surgeon evaluated the patient for post-operative recovery. At 10:45 the surgeon wrote an order for the patient to be discharged home. The patient was discharged home at 1420 hours. At 1800 hours (37 hours after the end of the case) an anesthesiologist came to evaluate the patient, but was not able to do so because the patient was no longer in the hospital. The anesthesiology policy and procedure titled "Postanesthesia Evaluation within 24 Hours" stated a post-anesthetic evaluation shall be performed on all patients receiving an anesthetic or sedation administered in the operating room. In an interview on 7/27/07 at 1010 hours the Chairman of the Department of Anesthesia stated hospital policy required a discharge evaluation for patients receiving anesthesia to be performed within 24 hours following anesthesia. The medical record of patient 98 does not contain a post-anesthesia evaluation with documentation of cardiopulmonary status, level of consciousness, and condition following anesthesia.	A1023		

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K 000	INITIAL COMMENTS K3 BUILDINGS: 01-03 K6 PLAN APPROVAL: Building 01 - 1968, Building 02 -1972, Building 03 - 1994 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: MULTIPLE STORY, CONCRETE CONSTRUCTION TYPE (1) (222), BUILDING 01 - PARTIALLY SPRINKLERED, BUILDINGS 02 AND 03 - FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during a Recertification Life Safety Code survey. The findings are in accordance with 42 Code of Federal Regulations 483.70 (a) and National Fire Protection Association 101, Life Safety Code 2000 Edition, Existing codes. Representing the California Department of Public Health, Life Safety Code Unit: Maxine McKaig, Health Facilities Evaluator and Anna Jaurigue, Health Facilities Evaluator	K 000		
K 012	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation the facility failed to ensure building construction meets all requirements, as evidenced by penetrations located in walls and	K 012		

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

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

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K 012	Continued From page 1 ceilings throughout the facility. Findings: During the facility tour with facility staff from July 23, 2007 through July 26, 2007, surveyors observed penetrations in the following areas: a. July 23, 2007: Hawkins Building - Second floor At 1420 hours there was an approximately 1/4 - 1/2 inch penetration around the smoke detector on the ceiling of storage area in the lab near 301B. At 1440 hours there were two approximately 1 inch penetrations and ten approximately 1/8 inch or less penetrations in the back wall of the lab room near the entrance to room 3003. There was an approximately 1/2 inch penetration around a screw in the front wall. b. July 24, 2007: Main Hospital Building - Basement At 1755 hours there was an approximately 1/8 inch penetration around a pipe near the back wall and an approximately 1/8 - 1/4 inch penetration around a pipe above the door, in the pipe chase room B045E. At 1800 hours there were eight approximately 1/2 - 3/4 inch penetrations around pipes and pipe sleeves in the ceiling above the front wall in electrical room BO45F. There was an approximately 2 - 4 inch penetration around 3 pipe sleeves in the front wall. There was an approximately 1/2 - 1 inch penetrations around 12 pipe sleeves in the ceiling above the back wall and four pipe sleeves in the ceiling above the left wall.	K 012		

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K 012	Continued From page 2 c. July 25, 2007: Main Hospital Building - Fifth floor At 1800 hours there were two approximately 1/8 inch penetrations around wires in two pipes penetrating the floor. Light was visible from the room below on the fourth floor. d. July 26, 2007: Main Hospital Building - Third floor At 1115 hours there was an approximately 1/4 inch unsealed penetration around a conduit penetrating the left wall in room 3018 located near unit 3A. At 1400 hours there was an approximately 1/8 - 1/4 inch penetrations around three separate pipe sleeves in the transformer room 3074A, in the surgery area. At 1408 hours there was an approximately 3/4 inch penetration around a pipe sleeve in the back wall and an approximately 1/4 inch penetration around a conduit in the right wall of the phone closet, room 3057, in the surgery area. At 1415 hours there was an approximately 1/8 inch penetration around a pipe sleeve in the front wall in the transformer room 3074, in the surgery area. e. Basement: At 1850 hours there was an approximately 1 1/2 inch round penetration around wires, in the ceiling of the supply area near the cart washing machine.	K 012		
K 021	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or	K 021		

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K 021	Continued From page 3 hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation the facility failed to maintain the magnetic hold-open devices on the smoke barrier doors as evidenced by two doors that failed to release automatically upon activation of the fire alarm, as required by NFPA 101, 9.6.5.2 Findings: During the testing of the fire alarm devices with facility staff on July 25, 2007, at 1423 hours one surveyor observed the smoke barrier doors located in the Acute Basement, entering the Ultrasound/Radiation/Oncology and Nuclear Medicine Department. Both doors are held open with magnetic devices and failed to release from the magnetic device upon activation of a smoke detector or pull station. The Director of Plant Management and the Director of the Mechanical	K 021		

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K 021	Continued From page 4 Department confirmed the doors failed to release and close.	K 021		
K 025	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation the facility failed to ensure that smoke barrier walls maintain a 1/2 hour fire resistance rating and are constructed in accordance with 8.3. as evidenced by one smoke barrier wall that had unsealed penetrations around pipes or wires. 8.3.2 - Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous throughout all concealed spaces, such as those found above a ceiling, including interstitial spaces. Findings: During the facility tour with facility staff on July 27, 2007, this surveyor observed the smoke barrier	K 025		

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K 025	Continued From page 5 walls located in the Trauma Building - Second floor, as follows: At 0858 hours the smoke barrier wall at the second floor elevator lobby had an approximately 1/2 inch penetration and an approximately 1/4 inch penetration around two separate pipe sleeves. Additionally there was an approximately 1 - 1 1/2 inch penetration in the middle area of the wall.	K 025		
K 027	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and inspection the facility failed to maintain it's fire rated smoke barrier doors, as evidenced by two sets of smoke barrier doors that failed to latch upon activation of the fire alarm system and one magnetic release device that was not maintained. Findings: During the testing of the fire alarm devices with the Director of Plant Management, Director of Mechanical Department and Facility Manager on	K 027		

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K 027	Continued From page 6 July 24, 2007 and July 25, 2007, the following smoke barrier doors failed to latch upon release from the magnetic hold open device during testing of the fire alarm system, as follows: a. July 25, 2007, Main Hospital Building-Fourth floor: At 1106 hours the one hour fire rated smoke barrier door between room 4018 and the elevator lobby failed to latch upon release from the magnetic device. b. July 25, 2007, Main Hospital Building, - Second floor At 1310 hours the magnetic device for the smoke barrier door outside of Hematology/Oncology was loose and was separating from the corridor wall. c. July 25, 2007, Main Hospital Building-First floor: At 1335 hours the smoke barrier double doors #1005, to the emergency department, closed during fire alarm testing. The left door failed to latch upon release from the magnetic device.	K 027		
K 052	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		

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K 052	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure maintenance, inspection and testing of the fire alarm system complying with applicable requirements of NFPA 70 and 72 as evidenced by the failures of multiple annunciation or illumination devices in the Main Hospital Building. Findings: During alarm testing and interview with facility staff on July 24, 2007 and July 25, 2007, surveyors observed fire alarm testing with facility staff, as follows: July 25, 2007: a. Main Hospital - Fourth floor: During fire alarm testing at 1055 hours, the audible/strobe device had no audible signal in the GI lab area employee bathroom. The strobe functioned but there was no audible alarm. b. During fire alarm testing at 1100 hours, the audible/strobe device had no audible signal in the GI lab area unisex bathroom. The strobe functioned but there was no audible alarm. c. Third floor: During fire alarm testing at 1122 hours, the audible/strobe device had no audible signal in 3E, in the blood draw area bathroom. The strobe functioned but there was no audible alarm. d. First floor: During fire alarm testing at 1333 hours, the strobe	K 052		

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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
K 052	Continued From page 8 in room 1086, the staffing office, failed to activate. The audible device in the waiting area next to the staffing office failed to activate an audible alarm. At 1351 hours two of two audible devices failed to activate during the testing of any fire alarm devices in the doctor's conference room. e. Basement: During fire alarm testing at 1418 hours, the audible/strobe device had no light signal in the corridor near room B004. The audible alarm functioned but there was no flashing strobe light. f. Sixth floor (penthouse): At 1505 hours the bell inside the door to the penthouse failed to chime during alarm testing. Another audible/strobe device in the area was audible within the penthouse. At 1506, interview with the facility manager revealed the bell was part of the old alarm system and was no longer operational. Interviews with the Director of the Mechanical Department, Director of Plant Management and the Facility Manager confirmed these devices were not working during testing of the fire alarm system.	K 052		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062		

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	050578	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/27/2007

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K 062	Continued From page 9 Based on observation, interview and record review the facility failed to ensure maintenance, inspection and testing of the sprinkler system was completed as required by NFPA 13 and NFPA 25, as evidenced by the failure of one inspector's test valve to activate the fire alarm system, by a leak of one control valve, and by escutcheon rings that were not flush with the ceiling. Findings: During the facility tour, interview and record review with facility staff on July 24, 2007, July 25, 2007, and July 26, 2007, surveyors observed the testing of the fire sprinkler system, and observed sprinkler heads located in the basement of the main hospital and in the Trauma building, as follows: July 24, 2007, Trauma Building - Basement: During fire alarm testing at 1220 hours opening the inspector's test valve in TO-119, failed to activate the fire alarm within 100 seconds. At 1225, interview with the sprinkler specialist revealed the valve sometimes sticks. The valve was retested at 1232 hours. The fire alarm system was activated within 52 seconds. b. Main Hospital - Basement: At 1740 hours the escutcheon ring was missing in the men's bathroom in the kitchen area. July 25, 2007, Main Hospital - Basement: During fire alarm testing at 1448 hours there was a leak at the control valve in B004F when the control valve was closed. Closing the control valve initiated a steady flow of water that was caught in an available bucket by the sprinkler	K 062		

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K 062	Continued From page 10 specialist. At 1452 hours interview with the sprinkler specialist revealed the parts had been ordered to repair the valve. During record review on July 26, 2007 and July 27, 2007 records of quarterly sprinkler testing and a purchase order confirmed the valve was leaking. The quarterly sprinkler testing reports indicated the valve had been leaking since October 2006. The purchase order indicated the part had been ordered on June 17, 2007. July 26, 2007, Main Hospital-Basement: a. At 1630 hours the escutcheon ring in the clean sterile supply area had an approximately 1/4 - 1/2 inch gap from the ceiling. A second escutcheon ring had an approximately 1/8 inch penetration on one side of the ring. There were approximately 30 sprinkler heads located in the clean sterile supply area. b. At 1645 hours the escutcheon ring in the clean sterile processing area had an approximately 1/4 inch gap from the ceiling. c. At 1647 hours the escutcheon ring above the crash cart washing machine in the decontamination area had an approximately 1/4 - 1/2 inch gap from the ceiling. d. At 1712 hours the escutcheon ring above the back counter, in the morgue, had an approximately 1/2 - 3/4 inch gap from the ceiling. July 27, 2007, Trauma Building - Basement: At 1000 hours two escutcheon rings were missing in the MRI computer room T0-40313.	K 062		
K 069	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance	K 069		

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K 069	Continued From page 11 with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and record review the facility failed to maintain it's fire suppression system as evidenced by failing to provide a UL 300 rated, fire suppression system for two of three kitchen areas. NFPA 96 section 7-2.2 requires that automatic fire extinguishing systems comply with standard UL 300. Findings: During the facility tour and record review with facility staff on July 24, 2007, this surveyor observed the kitchen suppression systems in the main kitchen, the cafeteria kitchen and in the doctor's kitchen and reviewed records for certification and cleaning of the kitchen hoods and vents. Record review at 0925 hours revealed the systems were certified in January and May 2007. The system certification completed on May 22, 2007, indicated the suppression systems in the doctor's kitchen and in the main kitchen do not meet "manufacturer and UL Specs." At 1730 hours the suppression system in the doctor's kitchen consisted of a HDR 25 pound KIDDE dry chemical system. The system is non UL 300 compliant. At 1745 hours the suppression sytem in the basement main kitchen consisted of a Range Guard 5.0 gallon, wet chemical system. The system is non UL 300 compliant. Interviews with the Director of the Mechanical	K 069		

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K 069	Continued From page 12 Department, the Director of Plant Management and the Facility Manager confirmed the system is not UL 300 compliant. An invoice from the vendor certifying the kitchen suppression systems revealed the systems had hydrostatic testing completed June 29, 2007. The facility was required to upgrade to a UL 300, wet chemical system by January 2006 or by the date hydrostatic testing was due.	K 069		
K 076	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation the facility failed to ensure the storage of medical gas is in accordance with NFPA 99 4-3.1.1.2 and NFPA 99 8-3.1.11.2 as evidenced by oxygen stored within 5 feet and 20 feet in non sprinklered rooms, of combustible supplies and by light switches and electrical outlets that were not located 60 inches from the floor. NFPA 99 - 8-3.1.11.2(c)(2) Storage for nonflammable gases less than 3000 cubic feet. (c) Oxidizing gases such as oxygen and nitrous	K 076		

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K 076	Continued From page 13 oxide shall be separated from combustibles or incompatible materials by either: 2. A minimum distance of 5 feet (1.5 m) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, or... (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d NFPA 99 - 4 -3.1.1.2(a) Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both) 4. The electric installation in storage locations or manifold enclosures for nonflammable medial gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage. 7. Combustible materials, such as paper, cardboard, plastics and fabrics shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage. Findings: During the facility tour with facility staff on July 26, 2007 and July 27, 2007, surveyors observed oxygen storage throughout the facility. The facility failed to maintain oxygen storage areas free from combustibles, as follows: July 26, 2007, Main Hospital Building - Fourth floor: At 1048 hours in unit 4B, a vacant patient room	K 076		

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K 076	Continued From page 14 #18 (non sprinkled) was observed to be used as a storage room that had seven E oxygen cylinders stored within approximately five feet of cardboard boxes, equipment covered with plastic, and paper supplies.	K 076		