NUHW
NATIONAL UNION OF HEALTHCARE WORKERS

EXECUTIVE SUMMARY

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH SEPTEMBER 14, 2020 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS AT FOUNTAIN VALLEY REGIONAL MEDICAL CENTER

BACKGROUND

On July 1, 2020, Fountain Valley healthc are staff represented by the National Union of Healthcare Workers (NUHW) filed a complaint with the California Department of Public Health (CDPH), citing multiple infection control lapses at the hospital that put staff and patients at risk of contracting COVID-19.

In response to the complaint, CDPH surveyors investigated FVRMC and found enough violations to trigger a more expansive, facility-wide investigation for the Centers for Medicare and Medicaid Services (CMMS).

A team of CDPH surveyors made multiple site visits and interviewed hospital employees, including several NUHW-represented healthcare workers.

The results of their findings and the hospital's response were reported in a 33-page Statement of Deficiencies and Plan of Corrections dated September 14, 2020. **The report cites the systematic failure of hospital administration to prioritize the health and safety of patients and staff. We urge you to take these findings seriously and follow through on the corrective action that both CDPH and CMS require.** Click here for the full report.

THE REPORT DOCUMENTED FINDINGS IN THE FOLLOWING MAIN AREAS:

- **Governance**
- **Patient Rights to Privacy and a Care in Safe Setting**
- **Quality Improvement Activities**
- **Patient Care Assignments**
- **Infection Prevention Control and Antibiotic Stewardship**
- **Infection Control Program**

1. GOVERNANCE

- CDPH found that FVRMC's "Governing Body" (GB) failed to "assume responsibility for determining, implementing, and monitoring policies governing the hospital's total functions to ensure compliance with [Conditions of Participation] of Infection Prevention and Control and Antibiotic Stewardship Programs" and failed to "ensure an effective, active hospital-wide infection control program for the prevention, control, and investigation of infections and communicable diseases, including COVID-19."
- CDPH found that "the cumulative effect of these systemic practices resulted in the failure of the hospital's GB to ensure the provision of quality healthcare in a safe manner." The GB also failed to contract with telemedicine service providers in a manner ensuring that patient services complied with CMS requirements, and failed to maintain lists of all contracted services provided in the hospital, creating an "increased risk of substandard services being provided."

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2. PATIENT RIGHTS

- Personal Privacy: CDPH found that of the 25 medical records they reviewed, one patient's right to privacy was violated when a privacy curtain was not provided during the patient's dialysis treatment.
- Care in Safe Setting: CDPH identified multiple failures in infection control standards, on the Pulmonary and Telemetry units as well as the Definitive Observation Unit (DOU), Pediatric unit, Pediatric Intensive Care Unit (PICU), and Medical Intensive Care Unit (MICU). These failures placed patients at risk for "cross contamination" and "for the non-COVID patients to be exposed to the COVID-19 positive patients."
- The hospital failed to appropriately cohort patients (isolate suspected and confirmed COVID-19 positive patients in separate areas) and failed to assign dedicated care teams to provide care to such patients.
- In one incident, a COVID-19-positive pediatric patient was in a room right next to COVID-19 negative pediatric patient. In another, a COVID-19-positive adult MICU patient was roomed on the PICU, where multiple COVID-19 negative pediatric patients were receiving intensive care.

3. QUALITY IMPROVEMENT ACTIVITIES

- Fountain Valley failed to "identify and include ineffective hospital operational processes as an opportunity for improvement in their quality improvement activities related to COVID-19."

4. PATIENT CARE ASSIGNMENTS

- "The hospital failed to provide the dedicated nursing staff to the COVID-19 positive patients that required isolation for a highly infectious disease. This failure had the potential to spread this infectious disease to other patients and staff."
- During an interview with CDPH surveyors, the Chief Nursing Officer (CNO) stated having the dedicated staffing for COVID-19 and PUIs were not always possible due to staffing shortages and the CDC's guidelines were only suggestions."

5. INFECTION PREVENTION CONTROL AND ANTIBIOTIC STEWARDSHIP

- "The hospital failed to ensure an effective, active hospital-wide infection control program for the prevention, control, and investigation of infections and communicable diseases, including COVID-19," and "the cumulative effects of these systemic problems resulted in the hospital's inability to provide an effective hospital wide infection control program and increased the risk of cross contamination and the spread of infection in the facility."

6. INFECTION CONTROL PROGRAM

The hospital failed to have in place a required infection prevention and control program that "employs methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings." The CDPH report outlines examples of the hospital's failures to meet this requirement:

- Failure to cohort appropriately
- Failure to assign dedicated staff to the care of suspected and confirmed COVID-19 patients
- Placement of a PUI on the Oncology unit (occupied by immunocompromised patients undergoing chemotherapy)
- Placement of a COVID-19-positive patient on the OB/GYN unit where pregnant women receive care
- Inconsistent and incomplete use of Personnel Entering High Consequence Infectious Disease (HCID) Patient Room log forms to record which employees enter COVID-19-positive patient rooms and note the date, time, duration of contact and PPE worn
- Failure to ensure staff reported COVID-19 symptoms and exposures to management and provide adequate follow-up training to staff on COVID-19 infection prevention and online reporting protocols
- Failure to ensure the infection control surveillance tools were effectively used to collect accurate data
- Failure to provide separate break rooms and restrooms to staff assigned to COVID-19 positive patients
- Failure to ensure the hand hygiene was performed by the physicians after seeing patients

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