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

PRINTED: 08/05/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	050570		C 07/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN VALLEY REGIONAL HOSPITAL & MEDICAL CENTER	17100 EUCLID STREET FOUNTAIN VALLEY, CA 92708

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A 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the concurrent Focused Infection Control (FIC) survey and Complaint Validation Survey for Complaint Number: CA00695105. Inspection was limited to the Conditions of Participation reviewed and did not reflect the findings of a full inspection of the hospital. Representing the California Department of Public Health: Surveyors 21262, HFEN; 22553, HFEN; 37722, HFEN; 27231, HFES; and 31467, Medical Consultant. The surveyors entered the hospital on 7/14/20 at 1000 hours, and met with the hospital's administration team to inform of the surveys. The initial hospital census was 243. The survey sample size was 25 open and closed medical records. GLOSSARY OF ABBREVIATIONS AND DEFINITIONS: CDC - Center for Disease Control and Prevention CMS - Centers for Medicare and Medicaid Services CNA - Certified Nursing Assistant CNO - Chief Nursing Officer Cohorting - Grouping of patients who have the same infectious disease physically separated from other patients without the confirmed disease. COP - Condition of Participation COVID-19 - Coronavirus Disease 2019 Dedicated staff - Healthcare personnel (HCP)	A 000	The plan of correction is prepared in compliance with federal regulations and is intended as Fountain Valley Regional Hospital and Medical Center's credible allegation of compliance. The submission of the plan of correction is not an admission by the facility that it agrees that the citations are correct or that it violated the law **Organization Minutes:** The confidential and privileged minutes are being retained at the facility for agency review and verification upon request **Exhibits:** All exhibits including revisions to Medical Staff Bylaws, reviewed/revised or promulgated policies and procedures, documentation of staff and medical staff training/education are retained at the facility for agency review and verification upon request.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kenneth D. Martin | TITLE: CEO | (X6) DATE: 9/8/2020

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.

[redacted]

9-14-20 #21262

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A 000	Continued From page 1 working only on Covid-19 care unit who should have their restroom, breakroom and work area separated from HCP working in other areas of the facility. DOU - Direct Observation Unit FAQs - Frequently Asked Questions GB - Governing Body HCID - High Consequence Infectious Disease log HCP - Healthcare personnel HHS - Health and Fuman Resources ICU - Intensive Care Unit ID - Identification IV - intravenous MEC - Medical Executive Committee MICU - Medical Intensive Care Unit N95 mask - Fitted Filtering facemask up to 95% OB/GYN - Obstetrician/Gynecology P&P - policy and procedure PACU - Post Anesthesia Care Unit PICU - Pediatric Intensive Care Unit PPE - Personal Protective Equipment (i.e., gown, gloves, eye protection, respirator) Pre-op - Pre-operative PT - Physical Therapist/Therapist PUI - Person under Investigation QAPI - Quality Assurrance and Performance Improvement Respirator - Personal protective device that is worn on the face, covers the nose/mouth used to reduce wearer's risk of inhaling hazardous airborne particles RN - Registered Nurse RT - Respiratory Therapist/Therapist SARS-Cov-2 - the virus that causes COVID-19	A 000		
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is	A 043		

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A 043	Continued From page 2 legally responsible for the conduct of the hospital. 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 observation, interview, and record review, the GB failed to assume responsibility for determining, implementing, and monitoring policies governing the hospital's total functions to ensure compliance with COPs under 482.42 (Infection Prevention and Control and Antibiotic Stewardship Programs). The GB 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. Cross reference to A747. 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.	A 043	**Response:** The Governing Board is in receipt of the report written by The Centers of Medicare and Medicaid (CMS) dated August 27, 2020. The Governing Board has taken the allegations of deficiency in the report very seriously and continues to assume full responsibility for determining, implementing and monitoring policies governing the hospital's total operation and for ensuring that these policies are administered to protect and promote patient safety, and provide efficient, effective, quality health care. The Governing Board continues to hold the Chief Executive Officer, hospital leadership, hospital staff and the medical staff responsible for adherence to established policies and procedures through the routine reporting, analysis, and action of the hospital's infection control and surveillance activities. This includes the maintenance of an effective hospital-wide infection control program for the prevention, control and investigation of infections and communicable diseases including pandemics.	8/27/2020
A 052	MEDICAL STAFF CFR(s): 482.12((a)(8), (a)(9) [The governing body must:] (8) Ensure that, when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital, the agreement is written and that it specifies that it is the responsibility of the governing body of the distant-site hospital to meet the requirements in paragraphs (a)(1) through (a)(7) of this section	A 052		

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A 052	Continued From page 3 with regard to the distant -site hospital's physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(3) of this part, grant privileges based on its medical staff recommendations that rely on information provided by the distant-site hospital. (9) Ensure that when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site telemedicine entity, the written agreement specifies that the distant-site telemedicine entity is a contractor of services to the hospital and as such, in accordance with §482.12(e), furnishes the contracted services in a manner that permits the hospital to comply with all applicable conditions of participation for the contracted services, including, but not limited to, the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant-site telemedicine entity ' s physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(4) of this part, grant privileges to physicians and practitioners employed by the distant-site telemedicine entity based on such hospital's medical staff recommendations; such staff recommendations may rely on information provided by the distant-site telemedicine entity. This STANDARD is not met as evidenced by: Based on interview and record review, the GB failed to ensure the written agreement between the hospital and telemedicine neurology physicians group included a provision that the	A 052	**Policy and procedure** The Chief Operating Officer, the Chief Nursing Officer and the Director of Quality requested that the Regulatory Group, Senior Counsel review the Tele neurology agreement to determine if the agreement included a provision that the teleneurology physician group (Group) would provide clinical services that complies with all CMS CoPs. Review of the agreement confirms that it does include a comprehensive compliance statement in the section related to the Group's representations and warranties. See Section 5. The agreement states in Section 5(v) Group and each physician shall perform the services required hereunder in accordance with all applicable federal, state and local laws, rules and regulations, all applicable standards of The Joint Commission and any other relevant accreditation organizations. In Section 2(iii) of the agreement, Professional Qualifications, it requires that each physician participate in the Medicare and State Medicaid Programs. This requirement to participate in the Medicare and State Medicaid Program is also present in Section 5(vi) of the agreement.	

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A 052	Continued From page 4 neurology physicians group would provide clinical services that complied with all CMS COP's. This increased the risk the hospital may not be in full compliance with all CMS COP's. Findings: Review of the hospital's P&P titled Rules and Regulations of the Governing Board of Fountain Valley Regional Hospital and Medical Center dated 5/29/18, showed in part, "...The functions and duties of the GB...consistent with the standards of The Joint Commission on Accreditation of Healthcare Organizations...and applicable laws and regulations..." Review of the hospital's P&P titled Bylaws, general rules and regulations of the medical staff dated 3/2019 showed in part, "...Telemedicine Practitioner means any licensed and appropriately credentialed practitioner who only prescribes, renders a diagnosis or otherwise provides clinical treatment to a hospital patient by telemedicine who has expressly applied for and been granted Telemedicine privileges. Telemedicine practitioners must meet the qualifications for membership outlined in Article II, Section 2.2..." Review of the Contract Services Evaluation Executive Summary dated 10/24/19, showed, "The governig body has the responsibility for assuring that hospital services are provided in compliance with the Medicare Conditions of Participation and according to acceptable standards of practice irrespective of whether the services are provided directly by the hospital emplyees or indirectly by contract..."	A 052		

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A 052	Continued From page 5 Review of the Emergency Room On-Call Agreement for stroke patients dated 11/22/19, showed no documented evidence of the statement that the neurology physicians group would provide clinical services that complied with all CMS COPs. During an interview with the Director of the Medical Staff on 7/21/20 at 0945 hours, she agreed with the finding.	A 052		
A 085	CONTRACTED SERVICES CFR(s): 482.12(e)(2) The hospital must maintain a list of all contracted services, including the scope and nature of the services provided. This STANDARD is not met as evidenced by: Based on interview and record review, the GB failed to ensure the complete list of all contracted services provided in the hospital was maintained. This created the increased risk of substandard services being provided. Findings: Review of the hospital's P&P titled Rules and Regulations of the Governing Board of Fountain Valley Regional Hospital and Medical Center dated 5/29/18, showed in part, "...The Governing Board shall review at least annually (i) the quality of service rendered by hospital-based physicians and other professional service contractors, and (ii) the need for and selection of such hospital-based physicians and professional service contractors..." Review of the hospital's contracted services list	A 085	**Policy & Procedure** The Chief Operating Officer added a review of all contracts to the items on the Governing Board reporting calendar. The Chief Operating Officer is responsible to make certain that a list of all contracted services, not only clinical contracted services, will be reviewed by the Governing Board at least annually. The Governing board reviewed a complete list of contracted services on August 27, 2020. **Education and Training** The Chief Executive Officer and the Chairman of the Governing Board reviewed the current Rules and Regulations of the Governing Board of Fountain Valley Regional Hospital and Medical Center, and no revisions were required.	8/27/2020 8/27/2020

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A 085	Continued From page 6 was initiated on 7/16/20. The contracted services list included all contracts for clinical services, but the non-clinical vendors were not listed. During an interview with the Director of Quality on 7/16/20 at 1015 hours, the Director of Quality provided the list of contracted services showing only clinical contracted services. However, the Director of Quality was unable to provide the complete list of contracted services which included the non-clinical contracted services.	A 085	**Monitoring** The Chief Operating Officer will audit the list of contracts sent to the Governing Board for annual review on August 27, 2020, to confirm that all contracts are included. The Chief Operating Officer will report the results of the monitoring to the Quality Patient Care Committee and Medical Executive Committee. **Responsible Personnel** Chief Operating Officer	
A 143	PATIENT RIGHTS: PERSONAL PRIVACY CFR(s): 482.13(c)(1) The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to ensure the privacy was provided to one of 25 sampled patients (Patient 25) during the medical treatments. This had the potential to violate the patient's privacy right during the medical treatment. Findings: On 7/14/2020 at 1225 hours, during the PICU tour with the Director of ICU/DOU. The PICU was observed to be used for the MICU and DOU adult patients. There were eight private patient rooms and one shared room. The shared room was occupied by three MICU patients in Beds 9, 10, and 11. Each bed had the patient privacy curtains. The following was observed: - For Bed 9, the patient was ambulating at the bedside with assistance.	A 143	**Disciplinary Action** Noncompliance with corrective action by hospital staff will result in immediate remediation and the proper disciplinary action in accordance with the hospital's Human Resources Policies and Procedures **Policy & Procedure** The Chief Nursing Officer reviewed the Patient Right to Privacy Policy to confirm it meets current standards and requirements and no revisions were required. **Education and Training** The Department Directors or their designee of departments that provide direct patient care educated their staff on patient rights and on the patient's right to privacy, during daily staffing huddles, staff meetings, and one on one education.	7/24/2020 7/31/2020

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A 143	Continued From page 7 - The patient in Bed 10 had an IV medication infusion. - For Bed 11, Patient 25 was on hemodialysis. The dialysis nurse was observed working on the patient's dialysis access site. However, there was no privacy curtain used to provide the privacy during the time Patient 25 receiving dialysis treatment. The Director ICU/DOU confirmed the observation.	A 143	**Monitoring** The Departmental Directors or their designee conduct daily rounding and verify that the patient's privacy is protected through the closing of doors and curtains when any procedure or patient care is being performed. Any identified breach will be addressed through real time education and corrective actions. Monitoring will occur for 3 months with 100% compliance. The Director of Quality Services reports the results of the monitoring to the Quality Patient Care Committee and Medical Executive Committee at least quarterly as part of the performance improvement plan.	
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care in a safe environment based on the infection control standards of practice for the patients on the Medical Pulmonary unit of the East Tower, Medical Telemetry of the main hospital building, DOU, Pediatric unit, PICU, and MICU. This failure had the potential for cross contamination for the non-COVID patients to be exposed to the COVID-19 positive patients. Findings: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Setting updated 5/18/20, showed to keep the patients and healthcare personnel (HCP) healthy and safe, it is generally recommended that the patients with COVID-19 be transferred to a separate area of	A 144	**Responsible Personnel** The Chief Nursing Officer **Disciplinary Action** Noncompliance with corrective action by hospital staff will result in immediate remediation and the proper disciplinary action in accordance with the hospital's Human Resources Policies and Procedures	

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A 144	Continued From page 8 the facility where they can be cared for by the dedicated HCP. Dedicated means that HCP are assigned to care only for these patients during their shift. On 7/14/20, review of the hospital's P&P for Preparedness and Response to Pandemic Viruses, effective on 5/2018 showed one of the procedures would be no "Cohorting." In a pandemic situation, large numbers of patients might present to the hospital and all available Airborne Isolation Rooms might be filled. Infection Control might deem it necessary to cohort patients on an isolation ward (in-hospital or alternative site) by following Health and Human Services (HHS) guidelines with "designated areas or units used for cohorting pandemic viruses to prevent cross-transmission of respiratory viruses, whenever possible, and only patients with confirmed pandemic virus to the same room or isolation unit. Assigned personnel should not float to other patient care areas and the number of personnel entering the cohorted area would be limited, because of the high patient volume anticipated during a pandemic; cohorting would be implemented early in the course of a local outbreak. 1. On 7/14/20 at 1100 hours, a tour of the Medical Pulmonary unit located on the second floor of the East Tower was conducted with the RN Manager of 2/3 East Tower. Rooms 254, 258, 260, 262, 282, 284, 286, and 290 A were COVID-19 positive patient rooms with two PUI patient rooms, Rooms 282 and 290 B. On 7/14/20 at 1100 hours, an interview was conducted with the RN Manager 2-3 East Tower.	A 144	**Policy & Procedure** The Chief Nursing Officer and the Infection Preventionist reviewed current federal and state guidelines and CDC recommendations for the care of patients with suspected or confirmed COVID-19. The Chief Nursing Officer and Infection Preventionist reviewed and revised the Policy Preparedness and Response to Pandemic Viruses to include cohorting strategies. Revisions were completed 8/27/2020. Hospital leadership identified designated COVID care areas on each level of care. Each designated COVID area is separated from non-COVID areas by a physical barrier and appropriate signage. The hospital completed these modifications to patient placement on 7/31/2020. **Education and Training** The Chief Nursing Officer educated the Unit Directors, Ancillary Services Directors and House Supervisors, on the designated COVID care areas. The Directors educated their staff on the COVID care locations through shift huddles and staff meetings. Education was completed on 7/31/2020.	8/27/2020 7/31/2020 7/31/2020

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A 144	Continued From page 9 The RN Manager 2-3 East Tower stated the COVID-19 and PUI patients were not cohorted (a grouping of patients with a given infection within an isolated area together in the same area and it was not possible to have assigned dedicated nursing staff for COVID-19 and PUI patients. 2. On 7/14/20 at 1247 hours, an initial tour of the Medical Telemetry unit on the second floor of the main hospital building was conducted with the Director of Telemetry. The Director of Telemetry stated the current census on the unit were 42 patients which included 15 COVID-19 positive patients. During the tour, the rooms of the COVID-19 positive patients were observed not being cohorted in one area of the telemetry unit. On 7/14/20 1400 hours, the Manager of Quality was asked to identify the COVID-19 positive patients on the floor map of the Medical Telemetry Unit. Review of the identified COVID patient room on the floor map showed the COVID-19 positive patients rooms were Rooms 203, 204, 205, 210, 219, 221, 223 A and B, 224, 225, 226, 227, 231, and 234. These COVID-19 patients rooms were not cohorted in one area of the unit. On 7/15/20 at 0900 hours, a tour of the Medical Telemetry floor on the second floor in the main hospital was conducted with the Director of Telemetry. Rooms 201, 202, 203, 204, 209, 210, 219, 221, 223, 224, 225, 226, 227, 231, and 234 were the COVID-19 positive patient rooms. On 7/15/20 at 0930 hours, an interview was conducted with the Med/Tele Director of Telemetry. The Director of Telemetry stated the COVID-19 and PUI patients were not cohorted on	A 144	**Monitoring** The Director of Quality reviews patient placement of COVID and non-COVID patients on a daily basis. The Infection Preventionist reviews patient placement twice daily. The House Supervisor is ensuring proper placement of patients on an ongoing basis, but at a minimum every two hours. Monitoring of patient placement for COVID and non-COVID patients will be ongoing with 100% compliance as bed availability allows. Monitoring will occur for 3 months with 100% compliance. The hospital will determine at the end of three months of 100% compliance the frequency of on-going monitoring. The Director of Quality reports results of the monitoring to the Quality Patient Care Committee and Medical Executive Committee at least quarterly as part of the performance improvement plan. **Responsible Personnel** Chief Nursing Officer Director of Quality **Disciplinary Action** Noncompliance with corrective action by hospital staff will result in immediate remediation and the proper disciplinary action in accordance with the hospital's Human Resources Policies and Procedures	

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A 144	Continued From page 10 the unit, and the staff had to take care of both COVID-19 and non-COVID patients. 3. On 7/15/2020 at 1019 hours, during the tour in the DOU with the Director of Rehab/Bariatrics and Manager of PACU/Pre-Op. Patient 12 who was the negative COVID-19 patient was observed ambulating in the hallway with the physical therapist. Further observation showed the patient rooms next to Patient 12's room on both side were the COVID-19 positive isolation rooms. 4. On 7/17 /2020 at 0750 hours, the Pediatric unit was toured. The board in the unit showed there were four patients admitted. During the concurrent interview with Pediatric Unit Secretary, she stated the unit had four patients, including one patient with positive COVID-19. This positive COVID-19 patient room was next to the COVID-19 negative patient. 5. On 7/17/2020 at 0758 hours, the PICU was toured with the Manager of Quality. The PICU board showed seven patients were on the unit as follows: - Two pediatric COVID-19 negative patients were in Rooms 2 and 4. - Four MICU adult patients included one COVID-19 positive in Room 6 and three COVID-19 negative in Beds 9, 10, and 11. - One adult DOU COVID-19 negative patient who required contact isolation was in Room 8. 6. On 7/17/2020 at 0816 hours, the MICU was toured with the Manager of Quality and Director of ICU/ DOU. The MICU board showed the census was 18 patient. The unit had some private rooms (Rooms 10-17) and sections with the patient beds	A 144		

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A 144	Continued From page 11 (#18-#28) separating by the privacy curtains or clear plastic dividers. The following was observed: - Rooms 10 and 11 had the negative COVID-19 patients. - Room 15 had the PUI patient. - Rooms 12, 14, 16, and 17 had the positive COVID-19 patients. - The sections for Bed #18 - #28 (with privacy curtain/dividers) had the positive COVID-19 patients. The Director of ICU/DOU confirmed the findings. On 7/16/20 at 1115 hours, the hospital's Administration was informed of the identified concerns related to the COVID-19 positive patient rooms were scrattered through out the units and no dedicated staff only assigned to the COVID-19 positive patients. On 7/20/20 at 1100 hours, during the QAPI meeting with the hospital's adminstration staff, the CNO presented to the survey team the hospital's plan to cohort the COVID-19 positive patients with the assgined dedicated staff for the hospital's immediate implementation.	A 144		
A 283	QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3) (b) Program Data (2) [The hospital must use the data collected to - .....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities	A 283		

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A 283	Continued From page 12 (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to identify and include ineffective hospital operational processes as an opportunity for improvement in their quality improvement activities related to COVID-19. Findings: According to the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (Covid-19) Pandemic dated 7/15/20, showed in part, "...As a measure to limit HCP exposure and conserve PPE, facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with suspected or confirmed SARS-COV-2 infection. Dedicated means the HCP are assigned to care only for these patients during their shift..."	A 283	**Policy & Procedure** The Chief Nursing Officer and the Infection Preventionist reviewed the current federal and state guidelines and the CDC recommendations for the care of patients with suspected or confirmed COVID-19. The Director of Quality, the Chief Nursing Officer, the Chief Operating Officer and the Infection Preventionist reviewed the Performance and Improvement plan, the Rules and Regulations of the Governing Board of Fountain Valley Regional Hospital and Medical Center; and the Management of Health Care Personnel Potentially Exposed to COVID-19 PUI or Case to confirm that the documents met current standards. No revisions were required. The Infection Preventionist and the Director of Quality updated the Fountain Valley Infection Control FAQs to include the implemented changes to the patient placement protocols. The Chief Nursing Officer reviewed and revised the procedure for staffing so that COVID-19 patients and Patients Under Investigation (PUI) are cared for by dedicated staff as staff availability allows. This revised procedure was implemented on 7/24/2020. Hospital leadership identified designated COVID care areas on all levels of care. Each designated COVID area is separated from non-COVID areas by a physical barrier and appropriate signage. The hospital completed these modifications to patient placement on 7/31/2020.	7/24/2020 7/31/2020

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A 283	Continued From page 13 Review of the hospital's P&P titled Performance Improvement Plan 2020 showed in part, "...The data collected for priority and required areas are used to monitor the stability of existing processes, identify opportunities for improvement, and identify changes that lead to improvement and to sustain improvement..." Review of the hospital's P&P titled Rules and Regulations of the Governing Board of Fountain Valley Regional Hospital and Medical Center dated May 29, 2018, showed in part, "...The Governing Board shall require the Medical Staff and staffs of the Hospital departments/services to implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care, for identifying opportunities to improve patient care, and for identifying and resolving problems...(ii) use of planned and systematic procedures to objectively assess the quality of care provided, (iii) implementation of corrective action when problems or opportunities for improvement are identified..." Review of the hospital's P&P titled FVRH Infection Control FAQ's dated 4/8/20, showed in part, "...Cohorted Units. For Cohorted units with patients known to be infected with the same infectious disease (Covid 19 positive) when these patients are housed in the same location (i.e., Covid-19 patients residing in an isolation cohort)...Wear the same gown, facemask and face shield for repeated close encounters with several different patients..." Review of the hospital's P&P titled FVRH Infection Control FAQ's dated 5/29/20, showed in part, "...Cohorted COVID units. For cohorted units with patients known to be infected with the same	A 283	**Education and Training** The Chief Nursing Officer educated the directors on the change in staffing practices and assignments. The Chief Nursing Officer educated the Unit Directors, Ancillary Services Directors and House Supervisors, on the designated COVID care areas The Directors educated their staff on the COVID care locations through shift huddles and staff meetings. Education was completed on 7/31/2020. **Monitoring** The Directors monitor the dedicated staff for COVID-19 patients daily and on an ongoing basis as patient volumes and acuity changes. The Director of Quality reviews patient placement of COVID and non-COVID patients on a daily basis. The Infection Preventionist reviews patient placement twice daily. The House Supervisor is ensuring proper placement of patients on an ongoing basis, but at a minimum every two hours. Monitoring of patient placement for COVID and non-COVID patients will be ongoing with 100% compliance as bed availability allows. Monitoring will occur for 3 months with 100% compliance. The hospital will determine at the end of three months of	7/31/2020

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A 283	Continued From page 14 infectious disease (Covid 19 positive)..." Review of the hospital's P&P titled Management of Health Care Personnel Potentially Exposed to COVID-19 PUI or Case, undated, showed in part, "...Restrict entry to room to necessary caregivers only...Assign limited staff to provide care to possible cases..." Review of the CMS QSO-20-13 dated 3/30/20, showed in part, "...Plan for a surge of critically ill patients and identify additional space to care for these patients. Include options for...Separating known or suspected COVID-19 patients from other patients ("cohorting"). Identifying dedicated staff to care for COVID-19 patients..." 1. The hospital failed to assign the dedicated nursing staff to the COVID-19 positive patients that required transmission-based precautions. Cross reference to A397. 2. The hospital failed to ensure the monitoring of COVID-19 patients room placement to be physically separated from the non-COVID-19 patients and assignment of the dedicated staff as per the hospital's P&P. Cross reference to A749, example #1. During an observation on 7/14/20 at 1145 hours, on the OB unit, RN L showed the "Covid room" which was designated for the Covid-19 positive patients only. During a concurrent interview, she stated, "The Covid-19 positive patient's nurse is not restricted to that one patient (Covid-19 positive), she can help other patients (Covid-19 negative). "We all know how to use PPE, we are all educated."	A 283	100% compliance the frequency of on-going monitoring. The Director of Quality reports results of the monitoring to the Quality Patient Care Committee and Medical Executive Committee at least quarterly as part of the performance improvement plan **Responsible Personnel** Chief Nursing Officer Director of Quality Infection Preventionist **Disciplinary Action** Noncompliance with corrective action by hospital staff will result in immediate remediation and the proper disciplinary action in accordance with the hospital's Human Resources Policies and Procedures	

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A 283	Continued From page 15 During a group infection control interview on 7/14/20 at 1511 hours, the Director of Quality was asked if he recommended the RNs and CNAs, who assigned to take care of the Covid-19 positive patients, should also take care of the Covid-19 negative patients as well. The Director of Quality stated, "No." During a telephone group interview on 7/17/20 at 1120 hours, the CNO stated, "The hospital follows the transmission-based precautions, not follow the disease." When the CNO was asked about the care of the Covid-19 positive patients without the dedicated staff assigned to the only COVID-19 positive patients, she stated, "Sometimes, it is not possible to do cohorting the patients with this surge."	A 283		
A 397	PATIENT CARE ASSIGNMENTS CFR(s): 482.23(b)(5) A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to provide the dedicated nursing staff to the COVID-19 positive patients that required isolation for to a highly infectious disease. This failure had the potential to spread this infectious disease to other patients and staff. Findings: The CDC's guidelines titled Coronavirus Disease	A 397	**Policy & Procedure** The Chief Nursing Officer and the Infection Preventionist reviewed the current federal and state guidelines and the CDC recommendations for the care of patients with suspected or confirmed COVID-19. The Director of Quality, the Chief Nursing Officer, the Chief Operating Officer and the Infection Preventionist reviewed the Performance and Improvement plan, the Rules and Regulations of the Governing Board of Fountain Valley Regional Hospital and Medical Center, and the Management of Health Care Personnel Potentially Exposed to COVID-19 PUI or	

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A 397	Continued From page 16 2019 showed the facilities should designate units with dedicated (assigned to care for only COVID-19 patients) HCP to care for the patients with known or suspected COVID-19. Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Setting updated 5/18/20, showed to keep the patients and HCP healthy and safe; it is generally recommended that the patients with COVID-19 be transferred to a separate area of the facility where they can be care for by the dedicated HCP. Dedicated means that HCP are assigned to care only for these patients during their shift. On 7/14/20 at 1000 hours, a tour of the Medical Pulmonary unit located on the East Tower was conducted with the RN Manager 2-3 East Tower. The COVID-19 positive patient rooms were scattered throughout the unit, not cohorting in the same area on the unit. Cross reference to A144, example #1. On 7/14/20 at 1100 hours a document review was conducted with the RN Manager 2-3 East Tower. Review of the Staffing Assignment by Room list showed the staff took care of COVID-19/PUI patients and non-COVID patients. On 7/14/20 at 1100 hours, an interview was conducted with the RN Manager 2-3 East Tower. The RN Manager 2-3 East Tower stated the COVID-19 positive and PUI patients were not cohorted and it was not possible to have assigned the dedicated nursing staff for the COVID-19 and PUI patients.	A 397	Case to confirm that the documents met current standards. No revisions were required. The Infection Preventionist and the Director of Quality updated the Fountain Valley Infection Control FAQs to include the implemented changes to the patient placement protocols. The Chief Nursing Officer reviewed and revised the procedure for staffing so that COVID-19 patients and Patients Under Investigation (PUI) are cared for by dedicated staff as staff availability allows. This revised procedure was implemented on 7/24/2020. Hospital leadership identified designated COVID care areas on all levels of care. Each designated COVID area is separated from non-COVID areas by a physical barrier and appropriate signage. The hospital completed these modifications to patient placement on 7/31/2020. **Education and Training** The Chief Nursing Officer educated the Directors on the change in staffing practices and assignments. The Chief Nursing Officer educated the Unit Directors, Ancillary Services Directors and House Supervisors, on the designated COVID care areas The Directors educated their staff on the COVID care locations through shift huddles and staff meetings. Education was completed on 7/31/2020.	7/24/2020 7/31/2020 7/31/2020

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A 397	Continued From page 17 2. On 7/15/20 at 0900 hours, a tour of the Medical Telemetry unit (second floor) in the main hospital was conducted with the Director of Telemetry. The COVID-19 positive patient rooms were in different area throughout the Medical Telemetry floor. Cross reference to A144, example #2. On 7/15/20 at 0930 hours, an interview was conducted with RN 4. RN 4 stated there have been times when she had the COVID-19 positive and non-COVID patients to care for during her shift. On 7/15/20 at 1000 hours, an interview was conducted with the Director of Telemetry. The Director of Telemetry stated the COVID-19 patients were not "cohorted" in a certain area of the unit because the facility did not like moving the patients around and she did not always have the dedicated staff for the COVID-19 patients due to staffing shortages. On 7/16/20 at 1400 hours, an interview was conducted with the CNO. The 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.	A 397	**Monitoring** The Directors monitor the dedicated staff for COVID-19 patients daily and on an ongoing basis as patient volumes and acuity changes. The Director of Quality reviews patient placement of COVID and non-COVID patients on a daily basis. The Infection Preventionist reviews patient placement twice daily. The House Supervisor is ensuring proper placement of patients on an ongoing basis, but at a minimum every two hours. Monitoring of patient placement for COVID and non-COVID patients will be ongoing with 100% compliance as bed availability allows. Monitoring will occur for 3 months with 100% compliance. The hospital will determine at the end of three months of 100% compliance the frequency of on-going monitoring. The Director of Quality reports results of the monitoring to the Quality Patient Care Committee and Medical Executive Committee at least quarterly as part of the performance improvement plan	
A 747	INFECTION PREVENTION CONTROL ABX STEWARDSHIP CFR(s): 482.42 The hospital must have active hospital-wide programs for the surveillance, prevention, and control of HAIs and other infectious diseases, and for the optimization of antibiotic use through stewardship. The programs must demonstrate	A 747	**Responsible Personnel** Chief Nursing Officer Director of Quality Infection Preventionist **Disciplinary Action** Noncompliance with corrective action by hospital staff will result in immediate remediation and the proper disciplinary action in accordance with the hospital's Human Resources Policies and Procedures	

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A 747	Continued From page 18 adherence to nationally recognized infection prevention and control guidelines, as well as to best practices for improving antibiotic use where applicable, and for reducing the development and transmission of HAIs and antibiotic resistant organisms. Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in collaboration with the hospital-wide quality assessment and performance improvement (QAPI) program. This CONDITION is not met as evidenced by: Based on observation, interview, and record review, 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 as evidenced by: 1. The hospital failed to assign the dedicated nursing staff to care for the COVID-19 positive patients who required transmission-based precautions. Cross reference to A397. 2. The hospital failed to ensure the active infection control surveillance were in place to monitor compliance with the current hospital's P&P and CDC's guidelines. Cross reference to A749. 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.	A 747	**Response:** The Infection Prevention Control Program at Fountain Valley Hospital and the Policy Preparedness and Response to Pandemic Viruses are designed to provide processes for infection prevention and control among all departments and individuals within the organization. These programs are designed to provide information and support to all healthcare providers regarding the principles and practices of infection control in order to support the development of a safe environment for all who enter the facility. **Policy & Procedure** The Chief Nursing Officer and the Infection Preventionist reviewed the current federal and state guidelines and the CDC recommendations for the care of patients with suspected or confirmed COVID-19. The Chief Nursing Officer reviewed and revised the procedure for staffing so that COVID-19 patients and Patients Under Investigation (PUI) are cared for by dedicated staff as staff availability allows. This revised procedure was implemented on 7/24/2020. The Chief Nursing Officer and the Infection Preventionist reviewed the infection control surveillance procedure and the use of the High Consequence Infectious disease (HCID) Patient room	7/24/2020
A 749	INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(2)	A 749		

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A 749	Continued From page 19 The hospital infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings; This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure the active infection control surveillance were in place to monitor compliance with the current hospital's P&P and CDC's guidelines as evidenced by: 1. Failure to ensure the monitoring of COVID-19 patients room placement to be physically separated from the non-COVID-19 patients and assignment of the dedicated staff as per the hospital's P&P. 2. Failure to ensure the staff reported the COVID-19 exposure and signs and symptoms related to COVID-19 to the managers. 3. Failure to ensure the infection control surveillance tools were effectively used to collect accurate data. 4. Failure to ensure the patient worn a mask during the blood drawing procedure and the high touch area was disinfected after the blood drawing procedure. 5. Failure to ensure the privacy screen was in place to separate the pediatric and adult patient areas. 6. Failure to ensure the used gowns were properly placed.	A 749	log to confirm that the infection control surveillance procedure and log were current. No revisions were required. **Education and Training** The Chief Nursing Officer educated the Directors and Ancillary Directors on the change in staffing practices and assignments. The Infection Preventionist reviewed the HCID form with the Hospital Directors. The Department Directors educated their staff on the HCID form during staff huddles and staff meetings. **Monitoring** The Directors monitor the dedicated staff for COVID-19 patients daily and on an ongoing basis as patient volumes and acuity changes. Monitoring will occur daily for 3 months with 100% compliance. The hospital will determine at the end of three months of 100% compliance the frequency of on-going monitoring. The Unit Directors or their designee conduct daily rounds to ensure the HCID form is posted outside of all patient rooms and that it is being filled out completely by all employees entering the room. The Employee Health staff will audit the forms for completeness. Monitoring will occur for 3 months with 100% compliance. The Director of Quality reports results of the monitoring to the Quality Patient Care Committee and Medical Executive Committee at least quarterly as part of the performance improvement plan.	7/31/2020

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A 749	Continued From page 20 7. Failure to provide the separate breakrooms and restrooms for the staff who assigned to the COVID-19 positive patients. 8. Failure to ensure the hand hygiene was performed by the physicians after seeing the patients. These failures created the risk of cross-contamination and spread of infection. Findings: 1. On 7/14/20, review of the hospital's P&P on Preparedness and Response to Pandemic Viruses, effective on 5/2018, showed no "Cohorting." In a pandemic situation, large numbers of patients might present to the hospital and all available Airborne Isolation Rooms might be filled. Infection Control might deem it necessary to cohort patients on isolation ward (in-hospital or alternative site) by following Health and Human Services (HHS) guidelines....Designated areas or units would be used for cohorting pandemic virus to prevent cross-transmission of respiratory viruses, whenever possible, assign only patients with confirmed pandemic virus to the same room or isolation unit..... Assigned personnel should not float to other patient care areas and the number of personnel entering the cohorted area would be limited.....Because of the high patient volume anticipated during a pandemic, cohorting would be implemented early in the course of a local outbreak. Concurrent review of the hospital's FAQs showed, "Cohort only confirmed cases with the same	A 749	**Responsible Personnel** Chief Nursing Officer **Disciplinary Action** Noncompliance with corrective action by hospital staff will result in immediate remediation and the proper disciplinary action in accordance with the hospital's Human Resources Policies and Procedures	
		A749	**Policy & Procedure** The Chief Nursing Officer and the Infection Preventionist reviewed the current federal and state guidelines and the CDC recommendations for the care of patients with suspected or confirmed COVID-19. The Chief Nursing Officer reviewed and revised the procedure for staffing so that COVID-19 patients and Patients Under Investigation (PUI) are cared for by dedicated staff as staff availability allows. This revised procedure was implemented on 7/24/2020.	7/24/2020
			Hospital leadership identified designated COVID care areas on all levels of care. Each designated COVID area is separated from non-COVID areas by a physical barrier and appropriate signage. The hospital completed these modifications to patient placement on 7/31/2020.	7/31/2020

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN VALLEY REGIONAL HOSPITAL & MEDICAL CENTER	17100 EUCLID STREET FOUNTAIN VALLEY, CA 92708

(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 749	Continued From page 21 disease process." The patient would be placed in a single room with door closed. * Review of the hospital's timeline on 7/20/20 showed the following: - On 3/16/20, the PUI patients were moved to the Telemetry/Med Surg unit of the East Tower to create a designated unit. Non-PUI patients would be moved out of the Telemetry/Med Surg unit of the East Tower. - On 4/14/20, the East tower was closed - all patients moved back to the main hospital. - On 6/2/20, opening 3E (third floor of East Tower) - COVID-19 unit. - On 6/22/20, opening 4E (fourth floor of East Tower) - Oncology unit. 6/29/20, opening 2E (second floor of East Tower) - Medical Pulmonary. On 7/17/20 at 1000 hours, the diagrams of the hospital's units showing the highlighted COVID-19 and PUI patient rooms were reviewed with Director of Quality and showed the COVID-19 positive patient rooms were scattered throughout the units as follows: - The ICU was fulled with the COVID-19 positive patients, with four COVID-19 positive patients overflowed to the Med-Surg unit. - The DOU had three COVID-19 positive patients in Rooms 136 A, 137, and 155 A; and two PUI patients in Rooms 114 A and 156 A. - The Pediatric ICU had one COVID-19 positive	A 749	**Education and Training** The Chief Nursing Officer educated the directors on the change in staffing practices and assignments. The Chief Nursing Officer educated the Unit Directors, Ancillary Services Directors and House Supervisors, on the designated COVID care areas The Directors educated their staff on the COVID care locations through shift huddles and staff meetings. Education was completed on 7/31/2020. **Monitoring** The Directors monitor the dedicated staff for COVID-19 patients daily and on an ongoing basis as patient volumes and acuity changes. Monitoring will occur daily for 3 months with 100% compliance. The hospital will determine at the end of three months of 100% compliance the frequency of on-going monitoring. The Director of Quality reviews patient placement of COVID and non-COVID patients on a daily basis. The Infection Preventionist reviews patient placement twice daily. The House Supervisor is ensuring proper placement of patients on an ongoing basis, but at a minimum every two hours. Monitoring of patient placement for COVID and non-COVID patients will be ongoing with 100% compliance as bed availability allows. Monitoring will occur for 3 months with 100% compliance. The hospital will determine at the end of three months of	7/31/2020

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A 749	Continued From page 22 patient and the Pediatric floor had one patient in Room 147 A. - The Telemetry unit had nine COVID-19 positive patients from Rooms 223 B, 225 A, 226 A, 227 A, 231 A, 234 A, 201A, 202A, and 203A. - The Medical Pulmonary unit had three COVID-19 positive patients in Rooms 296 A/B, 294 B and 292 B; and PUI patient in Room 286 A. - The designated COVID-19 unit located on the Telemetry/Med/Surg in the East Tower had 27 COVID-19 positive patients (Rooms 306 A, 308 A,314 A/B, 316 A/B, 318 A, 320 A, 322 A/B, 324 A, 340 A, 342 A/B, 344 A/B, 346 A/B, 348 A, 352 A/B, 354 A, 356 A/B, 358, 360 B, and 362 A). The remaining rooms were non COVID-19 patients. - The Oncology unit with immunocompromised patients due to chemotherapy had one PUI in Room 412 A. - The OB/GYN unit also had one COVID-19 positive patient during the initial tour on 7/14/20. * The hospital failed to provide the dedicated nursing staff to the COVID-19 positive patients. Cross reference to A 397. Further review of the hospital's timeline showed the following: Ongoing activity: Daily, weekly, and monthly updates provided to the GB and MEC regarding the COVID-19 statistics, PPE availability, and the testing. However, the timeline including the QAPI data, trends, and graphs on 7/20/20, failed to	A 749	100% compliance the frequency of on-going monitoring. The Director of Quality reports results of the monitoring to the Quality Patient Care Committee and Medical Executive Committee at least quarterly as part of the performance improvement plan A749 (2) **Policy & Procedure** The Chief Nursing Officer, the Manager of Employee Health and the Infection Preventionist reviewed the current employee screening procedures to confirm they meet CDC and command center guidelines. No revisions to the current procedures were required. **Education and Training** The Chief Executive Officer and the Chief Nursing Officer re-reviewed staff screening procedures with all Department Directors during a Director meeting on 8/25/2020. The Department Directors re-educated staff on the screening procedures during daily huddles and staff meetings in September. The re-education stressed staff responsibility to report any symptoms related to COVID and that all staff should wear their masks. Compliance was confirmed by attestation. The Directors will remind staff of the screening procedures weekly during huddles.	7/24/2020 8/25/2020 9/4/2020

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A 749	Continued From page 23 show the monitoring of COVID-19 patients room placement, physically separated from the non-COVID-19 patients, and assigned to the dedicated staff as per the hospital's P&P. On 7/16/20 at 1115 hours, the hospital's Administration was informed of the identified concerns related to the COVID-19 positive patient rooms were scattered through out the units and no dedicated staff only assigned to the COVID-19 positive patients. On 7/20/20 at 1100 hours, during the QAPI meeting with the hospital's administration staff, the CNO presented to the survey team the hospital's plan to cohort the COVID-19 positive patients with the assigned dedicated staff for the hospital's immediate implementation. 2. One of the complaints under grievance was reviewed on 7/20/20, showed the Radiology Transporter tested positive for COVID-19 and was admitted to the hospital. During an interview with the Manager of Infection Control, Director of Radiology, and Manager of Employee Health Director showed the Radiology Transporter did report to the management that he was exposed to the family member who was tested positive with COVID-19, and was on quarantine at home. Per the Director of Radiology, the Radiology Transporter being asymptomatic was allowed to work as per the hospital's P&P and was mandated to wear a mask. The next few days, the Radiology Transporter admitted to five co-workers that he had coughing and sore throat but did not notify the management of having symptoms.	A 749	**Other Action:** The Infection Preventionist confirmed the screening information and process was posted on staff entrances and throughout the hospital. **Monitoring** The dedicated screeners will screen staff at the designated hospital entry points. Screener will report positive sign and symptoms to the applicable departmental director and employee health. Failure of employee to report symptoms when screened will result in disciplinary action. Monitoring will occur for 3 months with 100% compliance. At the end of the three months the hospital will re-evaluate the incidence of COVID and determine the frequency of screening. The Director of Quality will report the results of the monitoring to the Quality Patient Care Committee and Medical Executive Committee at least quarterly as part of the performance improvement plan. Department Directors will observe staff properly wearing masks during daily rounds, and any identified variance will be addressed directly with the employee. **Responsible Personnel** Chief Nursing Officer Department Directors Employee Health Manager	7/24/2020

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A 749	Continued From page 24 In a concurrent interview with the Manager of Employee Health, he stated, "The employee must have lied through the hospital screening process. Symptoms of cough and sore throat were part of routine questions in the screening process." The Manager of Employee Health stated the five co-workers were interviewed and stated the Radiology Transporter "takes his mask off to allow him to cough better." The five co-workers were then sent home for quarantine. When the Manager of Infection Control was asked why the five co-workers failed to report the Radiology Transporter was having symptoms, she acknowledged that despite the inservice education provided regarding COVID-19 infection prevention and the availability of online reporting, there was a need to follow-up and remind current staff. 3.a. On 7/15/20 at 0922 hours, observation of the Oncology unit was conducted with the Patient Safety Officer and the Manager of Infection Control. Room 456 was observed to have an isolation signage outside of the door. However, the List of Personnel Entering High Consequence Infectious Disease (HCID) Patient Room log was not posted outside the patient's door. The Manager of Infection Control verified that there was no log available at the time. On 7/15/20 at 0920 hours, an interview was conducted with RN 3. RN 3 stated Patient 8 had an order dated 7/12/20 at 1636 hours, for isolation due to PUI. RN 2 verified Patient 8 was remained on isolation because there was no order to discontinue the isolation from the physician.	A 749	A749 (3) **Policy & Procedure** The Chief Nursing Officer and the Infection Preventionist reviewed the current federal and state guidelines and the CDC recommendations for the care of patients with suspected or confirmed COVID-19. The Chief Nursing Officer and the Infection Preventionist reviewed the infection control surveillance procedure and the use of the High Consequence Infectious disease (HCID) Patient room log to confirm that the infection control surveillance procedure and log were current. No revisions were required. **Education and Training** The Infection Preventionist reviewed the HCID form with the Hospital Directors. The Department Directors educated their staff on the HCID form during staff huddles and staff meetings. **Monitoring** The Unit Directors or their designee conduct daily rounds to ensure the HCID form is posted outside of all patient rooms and that it is being filled out completely by all employees entering the room. The Employee Health staff will audit the forms for completeness. Monitoring will occur for 3 months with 100% compliance. The Director of Quality reports results of the monitoring to the Quality Patient Care Committee and Medical Executive Committee at least quarterly as part of the performance improvement plan.	7/24/2020 7/31/2020

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A 749	Continued From page 25 On 7/15/20, Patient 8's medical record review was initiated. Patient 8 was admitted to the acute care hospital on 7/12/20. * On 7/15/20 at 0940 hours, tour of the Medical Surgical of the East Tower was conducted with the Patient Safety Officer and the Manager of Infection Control. Room 310 was a negative pressure and isolation room for Patient 9. There was no HCID log outside the patient's room door. The Manager of Med/Surg Pulmonary reviewed the patient's medical record and hospital binder, and verified there was no HCID log for Patient 9. On 7/15/20, Patient 9's medical record review was initiated. Patient 9 was admitted to the acute care hospital on 7/14/20. The medical record showed the patient was tested for COVID-19 and the result was still pending. * In addition, during the tour of the unit, the HCID log for Room 312 showed the last entry dated 7/12/20. The Manager of Med/Surg Pulmonary stated the HCID log was belonged to another patient who was moved to Room 346. * Review of the List of Personnel Entering High Consequence Infectious Disease (HCID) Patient Room log forms dated 3/27 and 6/4/20, showed the following information to be completed: - For 3/27/20 version, there were sections for the date, full name (staff), role/department, total time in the room (example 2 minutes), and PPE worn. - For the 6/4/20 version, there were sections for the date, full name, role/department, total time in room if greater than 15 minutes (yes or no), PPE worn, aerosol generating procedure (yes or no),	A 749	A749 (4) **Policy & Procedure** The Chief Nursing Officer and the Infection Preventionist reviewed the current federal and state guidelines and the CDC recommendations for the care of patients with suspected or confirmed COVID-19 to confirm that the process of masking all patients, when able to tolerate, and staff were completing high-touch surface disinfecting after patient care. **Education and Training** The Department Directors re-educated the staff on the importance of asking patients to wear a mask while the healthcare provider is in the room during shift huddles and staff meetings. in addition, staff was reminded to complete high-touch surface disinfecting prior to leaving the patient's room. **Monitoring** The Unit Director or their designee will conduct daily rounding to verify patients are wearing a mask while healthcare providers are in the patient's room, unless the patient is unable to tolerate a mask. The Directors will observe staff complete care and use the approved sanitizer cloth to disinfect high-touch surfaces. Monitoring will occur for 3 months with 90% compliance. The Director of Quality will report results of the monitoring to the Quality Patient Care Committee and Medical Executive Committee at least quarterly as part of the performance improvement plan.	7/24/2020 9/4/2020

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A 749	Continued From page 26 and patient mask (yes or no). On 7/21/20 at 0900 hours, an interview was conducted with the Manager of Infection Control. The Manager of Infection Control was asked for the hospital's P&P regarding the use of the List of Personnel Entering High Consequence Infectious Disease (HCID) Patient Room log posting outside of the patients' rooms. The Manager of Infection Control stated the hospital did not have a P&P related to the use of the log and they just used it as a resource tool for the surveillance log. She stated the leadership used the tool in addition to the medical record review and interview with staff for infection control surveillance. When asked if the staff were inserviced with the use of the log, she stated yes and as well as the managers of the units. The Manager of the Infection Control verified the two version of the surveillance log were used on the units. b. On 7/14/20 at 1100 hour, a tour of the 2nd floor Tower Medical Pulmonary floor was conducted with the RN Manager 2-3 East Tower. An observation of Room 260 showed the RT came out of the room. Posting on the room door was a sign-in list that showed no RT's name whom just came out of the room. On 7/14/20 at 1100 hours, an interview with the RN Manager of 2/3 East Tower was conducted. The RN Manager 2-3 East Tower stated the sign-in sheet (log) posted on the door was for the hospital's infection control to do contact tracing. The RN Manager 2-3 East Tower verified the RT failed to sign the log.	A 749	A749 (5) **Corrective Action:** The Director of Maternal Child Services reviewed the process of segregating adult patients from pediatric patient in the Pediatric Intensive Care Unit (PICU) with a physical barrier. **Education and Training** The Director of Maternal Child Services or their designee educated the nursing staff to place a physical barrier between pediatric and adult patients in the PICU. Education was provided during daily huddles and staff meetings. **Monitoring** When adult patients are in the PICU, the Director of Maternal Child Services or their designee will daily monitor the presence of a physical barrier separating adults and children. Nursing staff will confirm the presence of the physical barrier throughout their shift. Monitoring will occur for 3 months with 100% compliance. The Director of Quality will report results of the monitoring to the Quality Patient Care Committee and Medical Executive Committee at least quarterly as part of the performance improvement plan.	7/24/2020

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A 749	Continued From page 27 On 7/14/20 at 1500 hours, an interview with the Manager of Infection Control was conducted. The Manager of Infection Control stated the hospital did not have a P&P for the surveillance sign-in log for the patient rooms. The Manager of Infection Control stated all staff have been inserviced about the log. She stated it was a tool she started to track staff that could be exposed to the COVID-19 positive patients for infection control purposes. c. On 7/15/2020 at 0935 hour, during the tour in the MICU with the Director of ICU/DOU, it was observed that MICU #16 was the COVID-19 positive isolation room. Patient 16 was observed in bed with nasal oxygen cannula, not masked. Review of the posted "List of Personnel Entering High Consequence Infectious Disease (HCID) Patient Room" showed the patient had a mask on when Cardiology Tech 1 was scanning the patient. The scan was done at the right side of neck. However, during a concurrent interview with Cardiology Tech 1, she stated the patient's scan was for the right carotid (neck) and she did not put a mask on the patient. She stated she was not sure if the patient had a mask because the room was dark. She could not explain the reason why she documented the patient has a mask. Further interview was conducted with RN Q. RN Q stated the patient did not need to have the mask while in the room but should have the mask on when the visitor was in the room. d. On 7/15/2020 at 1200 hours, the Director of Quality provided Patient 14's List of Personnel Entering High Consequence Infectious Disease (HCID) Patient Room for review. The log showed the following:	A 749	A749 (6) **Policy & Procedure** The Chief Nursing Officer and the Infection Preventionist reviewed the current federal and state guidelines and the CDC recommendations for the care of patients with suspected or confirmed COVID-19 The Chief Nursing Officer and the Infection Preventionist reviewed and revised the policy and procedure on the reuse and extended use of Personal Protective Equipment (PPE) to remove the reuse of disposable gowns. The process has been updated to one time use for gowns and completed on 8/14/2020 **Education and Training** The Department Directors re-educated their staff on the change of practice of going to single use gowns. **Monitoring** The Unit Directors or their designees will conduct rounding to confirm all gowns are single use and not being reused and are disposed of correctly. Monitoring will occur for 3 months with 100% compliance. The Director of Quality will report the results of the monitoring to the Quality Patient Care Committee and Medical Executive Committee at least quarterly as part of the performance improvement plan.	8/24/2020 8/14/2020 8/14/2020

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A 749	Continued From page 28 - There was a lab person entered the room on "7/16," which would be a future date. - The log did not have a column to document "patient masked yes/no." During the concurrent interview with the Director of Quality, he stated the lab person documented the date which was for "tomorrow," instead of 7/15/20. The log was the old version "V 1.4, dated 3/27/2020" which had no space for documenting the masks. e. On 7/15/2020 at 1000 hours, during the tour with the Director of ICU/DOU in the Pediatric Unit. Patient 13 was a COVID positive patient. The log used was the V. 1.4 , 3/27/2020 for documenting the personal entering for care. There was no availability to document if the patient has mask "yes/no." On 7/15/2020 at 0930 hours, the Manager of Infection Control reviewed the above findings of the wrong date, not accurate information, and inconsistently version of log used on the floors/units. The Manager of Infection Control explained the log, List of Personnel Entering High Consequence Infectious Disease (HCID) Patient Room, was used to monitor and collect PPE data for trending the staff for properly use of PPE in the patient either with COVID-19 positive and PUI. The data could be used for investigation of employee exposure to the COVID-19 patients. The log V 1.4 3/27/2020 should have been discontinue and replaced by the new log V 1.6 6/4/2020, as per the CDC's guidelines. The hospital staff were trained and informed of the update log. Each unit Director and Manager were responsible to use the correct form.	A 749	A749 (7) **Policy & Procedure** The Chief Operating Officer and the Chief Nursing Officer identified dedicated breakrooms and bathrooms on each unit that has a COVID care area for staff caring for COVID patients and staff caring for non-COVID patients. The Director of Facilities and staff place signs identifying the separate breakrooms and bathrooms. The Director of Facilities and staff placed additional tables and chairs outside to provide additional break areas for staff. **Education and Training** The Unit Directors reviewed the locations of the dedicated breakrooms and bathrooms during shift huddles and staff meetings. **Monitoring** Unit Directors or their designees during daily rounding will observe that the dedicated staff caring for the COVID patients are using the specified breakrooms and bathrooms. Random observations will occur during rounding and any identified issues will be addressed with individual staff members. Monitoring will occur for 3 months. **Responsible Personnel** Chief Operating Officer	7/31/2020 7/31/2020

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A 749	Continued From page 29 4. On 7/14/2020 at 1225 hours, Phlebotomist 1 was observed obtaining a blood samples for Patient 14 in the PICU. Patient 14 was an adult COVID-19 positive patient and was not wearing a mask in the room. Phlebotomist 1 donned PPE and N 95 respirator, went into the room, explained the procedure, obtained the blood, and exited the room. The patient did not wear or was told to wear a face mask during the blood drawing procedure. In addition, while in the patient's room, the phlebotomist was observed touching the patient's bed rails, side table, and items on the table. There was no high touch surface disinfecting observed after the blood drawn by staff. 5. On 7/14/2020 at 1225 hours, during the tour in the PICU with the Director of ICU/DOU, the PICU was observed to have eight private rooms (Rooms 1 to 8) and one shared room for three beds (Beds 9, 10, and 11). The white privacy screen was observed in the hallway. The Director of ICU/DOU stated during the COVID-19 surge, the hospital flexed to use the PICU for the adult patients from the MICU and DOU. The unit divided the pediatrics and adult patients by the privacy screen. Phlebotomist 1 was observed walking toward the PICU side, pushing the privacy screen open, and looking for the adult patient. He was advised by the PICU staff that he was on the wrong side. * On 7/17/2020 at 0758 hours, the PICU was visited with the Manager Quality. The board with the unit census showed two pediatric COVID-19 negative patients in Rooms 2 and 4. In Room 6 was the adult COVID positive MICU patient. The privacy screen was not in place to separate the	A 749	Tag A749 (8) **Policy & Procedure** The Chief Nursing Officer and the Infection Preventionist reviewed the Hand Hygiene policy to confirm it meets current standards of care and practice. No revisions to the policy were required. **Education and Training** The Chief of Staff approved a memo sent to the medical staff on 8/20/2020 regarding regulatory findings and hand hygiene expectations **Monitoring** The unit directors or their designees will conduct 30 hand hygiene direct observation audits per month on each unit. Auditing will include all healthcare providers including physicians. Monitoring will occur for 3 months with 90% compliance. At the end of three months the hospital will evaluate the need and frequency of ongoing monitoring. The Director of Quality will report results of the monitoring to the Quality Patient Care Committee and Medical Executive Committee at least quarterly as part of the performance improvement plan.	7/24/2020

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A 749	Continued From page 30 pediatric COVID-19 negative and MICU COVID-19 positive adult patients. A concurrent interview with RN K (PICU nurse) was conducted. RN K stated she did not see the privacy screen there when her shift was started. The findings were confirmed with the Manager of Quality. 6. On 7/14/2020 at 1230 hours, a tour in the PICU was conducted with the Director of ICU/ DOU. The PICU had one room occupied with the COVID-19 positive patient. The yellow protective gown was observed being placed on top of the linen cart. During an interview, the Interim Manager of DOU/ICU stated the gown should be hanged up for reuse or discard in trash. 7. Review of the hospital's COVID-19 actions timeline showed the following: - On 7/7/20, the chairs were removed from the staff breakrooms and tents erected outside for breaks. - On 7/10/20, the Oncology visitor and DOU visitor waiting rooms were added as additional break areas for the employees. * However, initial tour of the Medical Pulmonary and Telemetry/Med Surg, the main COVID-19 units on the East Tower which had COVID-19, PUIs, and non-COVID-19 patients showed the staff caring for the COVID-19 and non-COVID-19 patients shared the same breakroom and restroom increasing the potential for cross-contamination. * On 7/14/2020 at 1255 hours, during the tour in the MICU, RN I stated the ICU breakroom was used for all ICU staff. There was no designated breakroom for the RNs who assigned to the PUI	A 749	**Responsible Personnel** Director of Medical Staff Services Director of Quality **Disciplinary Action** Noncompliance with corrective action by hospital staff will result in immediate remediation and the proper disciplinary action in accordance with the hospital's Human Resources Policies and Procedures. Noncompliance with corrective action by the Medical Staff will result in reporting to that physicians Department Chair and the Medical Executive Committee for remediation and disciplinary action.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING B WING	(X3) DATE SURVEY COMPLETED
	050570		C 07/22/2020

NAME OF PROVIDER OR SUPPLIER
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A 749	Continued From page 31 and COVID-19 positive patients. * On 7/15/2020 at 0900 hours, during an interview, the Director Rehab/Bariatrics stated the PTs' assignment was based on the daily patient needs. There was no designated breakroom for the PTs who cared for the COVID-19 positive and PUI patients. * On 7/15/2020 at 0928 hours, during an interview with RT 1 in the MICU, RT 1 stated the RT's assignment was based on the POINT system, not COVID-19 positive or negative status. The RTs provided care for COVID-19 positive, PUI, and COVID-19 negative patients. RT 1 acknowledged that there was no designated breakroom for the RTs who were assigned to the COVID-19 positive patients and/or non-COVID patients. * On 7/17/2020 at 0758 hours, a tour in the PICU was conducted. The census board showed two non-COVID-19 PICU patients, one DOU COVID-19 negative patient and one MICU COVID positive patient. The concurrent interview with RN K, she stated she was not aware of the designated breakroom for the RN who had COVID-19 positive patient assignment. They all shared the same restroom. 8. On 7/14/2020 at 1225 hours, during the tour in the PICU with the Director of ICU/ DOU, one physician was observed walking out of the multiple patient room after visiting the MICU patient. The physician was observed leaving the patient care area, touching the personal ID badge and exit door; however, the physician did not perform a hand hygiene. The Director of ICU/DOU confirmed the finding.	A 749		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING ____ B WING ____	(X3) DATE SURVEY COMPLETED C
	050570		07/22/2020

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A 749	Continued From page 32 * On 7/17/2020 at 0758 hours, during the tour in the PICU with the Manager of Quality. One physician was observed leaving the PICU after visiting the MICU adult patient. The physician was then observed walking into the Pediatric Unit hallway, scanning his ID badge, and pushing the exit door bar. There was no hand hygiene performed by the physician. The Manager of Quality confirmed the observation.	A 749		

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