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| A 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the California Department of Public Health during the COMPLAINT VALIDATION survey for COMPLAINT Numbers: CA00806675 and CA00806636.<br><br>Inspection was limited to the authorized Conditions of Participation reviewed and did not reflect the findings of a full inspection of the hospital.<br><br>Representing the California Department of Public Health: Surveyors 37548, HFEN and 40431, HFEN.<br><br>The complaint investigation was initiated on 10/12/22.<br><br>The survey team entered the hospital on 10/17/22 at 1200 hours, and met with the hospital's administration team to inform of the Complaint Validation survey.<br><br>The hospital identified the patient census as 245. The survey sample size was 17 open and closed medical records.<br><br>GLOSSARY OF ABBREVIATIONS AND BRIEF DEFINITIONS:<br><br>2 EAST: a nursing or inpatient care unit<br>3 EAST: a nursing or inpatient care unit<br>4 EAST: a nursing or inpatient care unit<br>Anemia: lack of red blood cells<br>Bilateral: having or related to two sides<br>Braden score/Pressure Ulcer Risk Score/Braden Risk Assessment/Braden Assessment: a score or | A 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael Carter — TITLE: Interim, Chief Executive Officer — (X6) DATE: 12/12/2022

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.

POC ACCEPTED
12/15/22
HFEN 40341

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| A 000 | Continued From page 1<br>assessment tool that used to predict the risk of developing pressure injury<br>Bronchoscopy/Bronch: a procedure to view the airways<br>CCO: Competent Constant Observer<br>CEO: Chief Executive Officer<br>CFO: Chief Financial Officer<br>CN: Charge Nurse<br>CNO: Chief Nursing Officer<br>CO: Constant Observer<br>Coccyx: tailbone<br>Code Blue: the hospital emergency code<br>COO: Chief Operating Officer<br>CoP: Condition of Participation<br>COVID-19: an infectious disease<br>Crash cart: a cart stocked with emergency medical equipment, supplies, and medications<br>Defibrillator: a device that send an electric shock to the heart to restore a normal heartbeat<br>Dialysis: a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly<br>DOU: Definitive Observation Unit<br>DTI: deep tissue injury<br>ED/ER: Emergency Department/Emergency Room<br>EKG: Electrocardiogram (a test that measures the electrical activity of the heart)<br>EMR: Electronic Medical Record<br>Eschar: a dry dark dead tissue<br>Feeder grower: the baby who needs to be able to eat independently and gain weight<br>Forceps: a surgical instrument<br>GB: Governing Body<br>H&P: History and Physical<br>HVAC: Heating, Ventilation, and Air Conditioning<br>ICU/CCU: Intensive Care Unit/Critical Care Unit<br>Incubator: a self-contained unit that is designed to provide a safe, controlled space for a baby | A 000 | | |

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| A 000 | Continued From page 2<br>Integumentary: the body ' s outer layer or skin<br>IP: Infection Preventionist<br>IV: Intravenous (within a vein or within the blood vessel)<br>L&D: Labor and Delivery<br>LIP: Licensed Independent Practitioner<br>Lipid: fat<br>MBCU: mother baby unit<br>NICU: Neonatal Intensive Care Unit<br>noc: night<br>OB: Obstetrics<br>P&P: Policy and Procedure<br>PEDS: Pediatrics (children)<br>Phlebotomy: a procedure in which a needle is used to take the blood from the blood vessel<br>PICU: Pediatric Intensive Care Unit<br>Plasma: the clear, yellowish, fluid part of the blood<br>Platelets: cells in the blood that slow or stop bleeding<br>PM: Preventive maintenance<br>Pneumatic tube system: a transport system in the hospital<br>PPE: personal protective equipment<br>PR: a part of EKG<br>PRBC: packed red blood cells<br>Pressure injury: bed sores<br>PRN: as needed<br>PUPP: Pressure Ulcer Prevention Protocol<br>QAPI: Quality Assurance and Performance Improvement<br>QMHP: Qualified Mental Health Professional<br>QMP: Qualified Medical Provider<br>QRS: a part of EKG<br>QT: a part of EKG<br>RN: Registered Nurse<br>Sacrum/Sacral: the area of a triangle bone in the lower back and tailbone<br>Slough: yellow, tan, or dead tissue | A 000 | | |

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| A 000 | Continued From page 3<br>SOAP: Subjective, Objective, Assessment, and Plan<br>STAT: immediately, without delay<br>Sterile: germ free<br>Subcutaneous: situated or lying under the skin<br>SURG: surgical unit<br>TELE: Telemetry (the practice of sending electronic signals from one place to another to allow the staff to monitor the patient's heart rate and rhythm)<br>Thermometer/Thermostat: a device used to measure temperature level<br>Thrombocytopenia: low blood platelet count<br>TPN: Total Parenteral Nutrition<br>Vacutainer: s sterile glass or plastic test tube<br>Venous: relating to vein, a type of blood vessel<br>Vital Signs: a group of important signs (temperature, pulse rate, respiratory rate, and blood pressure) | A 000 | | |
| A 043 | GOVERNING BODY<br>CFR(s): 482.12<br><br>There must be an effective governing body that is 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 ...<br><br>This CONDITION is not met as evidenced by:<br>Based on observation, interview, and record review, the hospital did not have an effective GB that carried out the functions required of a GB to provide a safe and secure environment for the patients as evidenced by:<br><br>1. The GB failed to develop, implement, and | A 043 | | |

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| A 043 | Continued From page 4<br>maintain an effective, ongoing, hospital wide, data driven quality assessment and performance improvement program. Cross reference to A263.<br><br>2. The GB failed to ensure the medical staff completed the medical records. Cross reference to A49.<br><br>3. The GB failed to ensure a well-organized or well-staffed nursing service to meet the needs of patients. Cross reference to A385.<br><br>4. The GB failed to ensure the hospital was maintained in a safe and sanitary manner. Cross reference A700.<br><br>The cumulative effect of these systemic problems resulted in the hospital's failure to deliver care in compliance with the CoP for GB and failure to provide a safe and secure environment for the patients. | A 043 | | |
| A 049 | MEDICAL STAFF - ACCOUNTABILITY<br>CFR(s): 482.12(a)(5)<br><br>[The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the hospital failed to ensure the medical staff provided quality of care for nine of 17 sampled patients (Patients 3, 4, 5, 8, 10, 12, 14, 15, and 17) when the medical staff did not accurately complete the medical records. These failures posed an increased risk of substandard health outcomes to the patients. | A 049 | | |

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| A 049 | Continued From page 5<br>Findings:<br><br>Review of the hospital's Bylaws, General Rules & Regulations of the Medical Staff dated 1/2022 showed the following:<br><br>* The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its content shall be pertinent and current. This record shall include identification data, complaint, personal history, history of present illness, physical examination, special reports such as consultations, clinical laboratory and radiology services, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, principal diagnosis, condition on discharge, discharge summary or discharge note, clinical resume, and autopsy report when performed.<br><br>* Pertinent progress notes shall be recorded at the time of each daily visit and shall be sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes.<br><br>* The hospital records (typed or electronic version), the patient's history and physical examination, including updates, in the medical record within 24 hours after registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services. This report should include all pertinent findings resulting from an assessment of all the systems of the body. This report must be validated and authenticated. | A 049 | | |

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| A 049 | Continued From page 6<br>1. On 10/20/22 at 0937 hours, review of Patient 17's medical record was initiated.<br><br>Patient 17's medical record showed the patient was admitted to the hospital on 10/16/22.<br><br>Review of the Admission H&P EMR No Cosign showed the following:<br><br>* The Chief Complaint section was left blank.<br><br>* The History of Present Illness section was left blank.<br><br>* The Past Surgical History section was left blank.<br><br>* The Social History section was left blank.<br><br>* The Review of Systems section was left blank.<br><br>* The Physical Exam section was left blank.<br><br>On 10/21/22 at 1111 hours, the findings were shared in the Governing Body Meeting and acknowledged by the Manager of Quality Services and Chief of Staff.<br><br>2. On 10/12/22 at 1453 hours, an interview and concurrent review of Patient 14's medical record was conducted with the Quality Director and Manager of Quality Services.<br><br>Patient 14's medical record showed Patient 14 was admitted to the hospital on 8/12/22.<br><br>Review of the Wound Care Note dated 9/1/22 at 1524 hours, showed the left buttock DTI had deteriorated to an unstageable pressure injury. | A 049 | | |

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| A 049 | Continued From page 7<br>Review of the Attending Physician Progress Notes dated 9/1, 9/2, 9/3/22, and the Discharge Summary dated 9/20/22, did not address Patient 14's unstageable pressure injury to the left buttock including the plan of care.<br><br>3. On 10/12/22 at 1200 hours, an interview and concurrent review of Patient 15's medical record was conducted with the Quality Director and Manager of Quality Services.<br><br>Patient 15's medical record showed Patient 15 was admitted to the hospital on 6/28/22.<br><br>Review of the Wound Care Note dated 9/13/22 at 1118 hours, showed Patient 15 had an unstageable pressure injury to the right heel.<br><br>Review of the Attending Physician Progress Notes dated 9/14 and 9/15/22, did not address Patient 15's unstageable pressure injury on the right heel including the plan of care.<br><br>The findings were shared with the Quality Director and Manager of Quality Services.<br><br>4. On 10/12/22 at 1315 hours, an interview and concurrent review of Patient 5's medical record was conducted with the Manager of Quality Services.<br><br>Patient 5's medical record showed the patient was admitted to the hospital on 8/16/22. Patient 5 developed an unstageable pressure injury to the sacrum/buttocks on 9/13/22.<br><br>When asked for the physician's progress notes addressing Patient 5's pressure injury to the sacrum/buttocks, the Manager of Quality | A 049 | | |

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| A 049 | Continued From page 8<br>Services stated, "there are none."<br><br>5. On 10/13/22 at 0940 hours, an interview and concurrent review of Patient 3's medical record was conducted with the Manager of Quality Services.<br><br>Patient 3's medical record showed the patient was admitted to the hospital on 8/31/22.<br><br>Review of the Wound Care Note dated 9/12/22, showed Patient 3 had an unstageable pressure injury to the sacrum area<br><br>When asked if there was any physician's progress note addressing Patient 3's pressure injury, the Manager of Quality Services stated no. The Manager of Quality of Services confirmed she was not able to provide the physician's progress notes addressing Patient 3's pressure injury.<br><br>6. On 10/13/22 at 1500 hours, an interview and concurrent review of Patient 4's medical record was conducted with the Manager of Quality Services.<br><br>Patient 4's medical record showed the patient was admitted to the hospital on 9/2/22.<br><br>Review of the Wound Care dated 9/23/22, showed Patient 4 had a Stage 3 pressure injury to the back.<br><br>There was also no documented evidence the physician had addressed the Stage 3 pressure injury on Patient 4's back. The Manager of Quality Services confirmed the findings. | A 049 | | |

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| A 049 | Continued From page 9<br>7. Review of the hospital's P&P titled Restraints & Seclusion dated 6/15/22, showed the following:<br><br>* Restraint orders must be renewed on a daily basis. A face-to-face physical examination is required by the physician or LIP every 24 hours for violent restraint to determine the clinical justification for the continued use of restraints. Restraint orders must be dated and timed when signed by the physician or LIP and include the criteria for release, type of restraint used, reason for restraint, and specify duration of restraint order.<br><br>* Maximum time for non-violent, non-self-destructive restraint is a calendar day based on physician face-to-face assessment.<br><br>* Attending physician or LIP must address continued need of restraints in daily progress entry.<br><br>a. On 10/20/22 at 1130 hours, an interview and concurrent review of Patient 10's medical record was conducted with the Manager of Quality Services.<br><br>Patient 10's medical record showed the patient was admitted to the hospital on 9/18/22.<br><br>Review of the physician's order dated 9/24/22 at 1932 hours, showed to apply two-point soft restraints to the bilateral upper extremities for Patient 10 as the non-violent restraint.<br><br>Review of the restraint flowsheets showed Patient 10 was restrained with two-point soft restraint on 9/24/22 at 1200, 1400, 1600, and 1800 hours; 9/25/22 at 2000 and 2200 hours; and 9/26/22 at | A 049 | | |

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| A 049 | Continued From page 10<br>0000, 0200, 0400 hours. There was no documentation to show the physician's order was written for the use of restraint when Patient 10 was restrained on 9/25/22.<br><br>Review of the physician order dated 9/26/22 at 1900 hours, showed to apply two-point soft restrains to the bilateral upper extremity to Patient 10. However, the physician's order did not show the reason for restraint use as the physician's order showed, "Interferes with Medical Devices, Medical device not present."<br><br>b. On 10/20/22 at 1212 hours, an interview and concurrent review of Patient 12's medical record was conducted with the Manager of Quality Services.<br><br>Patient 12's medical record showed the patient was admitted to the hospital on 10/8/22.<br><br>Review of the physician's order dated 10/15/22 at 0957 hours, showed to use two-point soft restraints to the patient's bilateral upper extremities due to interfering with medical device.<br><br>Review of another physician's order showed the RN updated the "Restraint to continue - Renewal Non-Violent (Completed)" for Patient 12 on 10/16/22 at 0843 hours.<br><br>However, there were no documentation to show the physician conducted a face-to-face assessment with Patient 12. There was no documentation to show the physician had validated the order for restraint use that was updated by the RN on 10/16/22.<br><br>8. On 10/20/22 at 1240 hours, an interview and | A 049 | | |

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| A 049 | Continued From page 11<br>concurrent review of Patient 8's medical record was conducted with the Manager of Quality Services.<br><br>Patient 8's medical record showed the patient was admitted to the hospital on 8/18/22.<br><br>Review of the physician's order dated 8/19/22 at 1203 hours, showed to transfuse one unit of platelet for Patient 8.<br><br>Review of the Progress Note EMR No Cosign SOAP dated 8/19/22 at 1202 hours, showed one unit of platelet would be given to Patient 8 and the patient agreed after the discussion of risks and benefits.<br><br>Review of the Blood Transfusion Information and Consent (with Physician Verification) showed Patient 8 signed the consent on 8/19/22 at 1430 hours. However, the physician did not sign and date the form to verify that the physician had discussed the advantages, disadvantages, risks, and benefits of the autologous blood and of directed and non-directed homologous blood from volunteers.<br><br>The Manager of Quality Service confirmed the findings. | A 049 | | |
| A 263 | QAPI<br>CFR(s): 482.21<br><br>The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.<br><br>The hospital's governing body must ensure that | A 263 | | |

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| A 263 | Continued From page 12<br>the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.<br><br>The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.<br><br>This CONDITION is not met as evidenced by:<br>Based on observation, interview, and record review, the hospital failed to develop, implement, and maintain an effective, ongoing, hospital wide, data driven quality assessment and performance improvement (QAPI) program as evidenced by:<br><br>1. Failure to ensure the QAPI program recognized the staffing issue and environment of care issues as opportunities for improvement. Cross reference to A283.<br><br>2. Failure to ensure documentation of GB oversight of staffing issues and environment of care issues. Cross reference to A315.<br><br>3. Failure to ensure an organized and sufficiently staffed nursing service to meet the needs of the patients. Cross reference to A385.<br><br>4. Failure to ensure the hospital's environment was maintained in a safe and sanitary manner. Cross reference A700.<br><br>The cumulative effect of the facility's failure to have a quality assurance system in place to ensure oversight of the hospital's nursing | A 263 | | |

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| A 263 | Continued From page 13<br>services resulted in the facility's failure to deliver and provide care to their patients in a safe environment. | A 263 | | |
| A 283 | QUALITY IMPROVEMENT ACTIVITIES<br>CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3)<br><br>(b) Program Data<br>(2) [The hospital must use the data collected to -.....]<br>(ii) Identify opportunities for improvement and changes that will lead to improvement.<br><br>(c) Program Activities<br>(1) The hospital must set priorities for its performance improvement activities that--<br>(i) Focus on high-risk, high-volume, or problem-prone areas;<br>(ii) Consider the incidence, prevalence, and severity of problems in those areas; and<br>(iii) Affect health outcomes, patient safety, and quality of care.<br><br>(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.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the hospital failed to ensure the QAPI program recognized the staffing issue and environment of care issues as opportunities for improvement. The QAPI program did not analyze the staffing issue and environment of care issues to use them as a learning opportunity, implement actions for | A 283 | | |

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| A 283 | Continued From page 14 | A 283 | | |

improvement, and evaluate whether actions were effective enough to sustain improvement. This failure created the risk of substandard health outcomes for the patients in the hospital.

Findings:

During the Complaint Validation survey from 10/12/22 through 10/21/22, the following deficient practices were identified:

* The nurse-to-patient ratios were not maintained for the ICU/CCU, NICU, PICU, DOU, 3 EAST, 4 EAST, TELE, 2 EAST, SURG, MBCU, PEDS, and ED. Cross reference to A392.

* The hospital was not maintained in a safe and sanitary environment. Cross reference to A700.

On 10/20/22, the QAPI meeting minutes for July and October 2021 and January, April, and July 2022 were reviewed. The QAPI minutes did not show documentation of the hospital wide staffing issues, including not maintaining the nurse-to-patient ratios for the ICU/CCU, NICU, PICU, DOU, 3 EAST, 4 EAST, TELE, 2 EAST, SURG, MBCU, PEDS, and ED. The QAPI minutes did not have documentation showing the environment of care issues on the hospital grounds.

On 10/21/22 at 1402 hours, the findings were shared with the Quality Director and Manager of Quality Services.

An interview was conducted with the Chief of Staff on 10/21/22 at 1111 hours. The Chief of Staff stated the GB was aware of the staffing challenges in the hospital and that it was an

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| A 283 | Continued From page 15<br>ongoing issue since the COVID-19 pandemic. The Chief of Staff stated the ongoing efforts were discussed and examples included recruitment, retention, registry nurses, and reaching out to corporate as needed. The Chief of Staff stated the environment of care issues were also ongoing and discussed in the GB meetings.<br><br>On 10/21/22, at 1419 hours, a interview was conducted with the CNO (over a telephone), Quality Director, and Manager of Quality Services regarding staffing issues, including the efforts to maintain the hospital nurse-to-patient ratios. The CNO stated the staffing issues were reported to the Medical Executive meetings and GB. | A 283 | | |
| A 315 | PROVIDING ADEQUATE RESOURCES<br>CFR(s): 482.21(e)(4)<br><br>[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 the following:]<br><br>(4) That adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the hospital failed to ensure the GB meeting minutes included documentation related to quality data and analysis reports regarding staffing and environmental issues. There was no documentation in the meeting minutes that the | A 315 | | |

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| A 315 | Continued From page 16<br>GB made any recommendations regarding the multiple staffing issues or the environment of care issues. As a result, there was no documented evidence the GB was ensuring that adequate resources were provided for the hospital's operation and care of patients, which had the potential to negatively affect patient care.<br><br>Findings:<br><br>During the Complaint Validation survey from 10/12/22 through 10/21/22, the following deficient practices were identified:<br><br>* The nurse-to-patient ratios were not maintained for the ICU/CCU, NICU, PICU, DOU, 3 EAST, 4 EAST, TELE, 2 EAST, SURG, MBCU, PEDS, and ED. Cross reference to A392.<br><br>* The hospital was not maintained in a safe and sanitary environment. Cross reference to A700.<br><br>Review of the GB meeting minutes for March, April, May, June, July, August, and September 2022, was conducted on 10/21/22. The GB meeting minutes showed the following:<br><br>* The 3/24/22 GB meeting minutes did not show quality data and analysis reports related to the staffing issues or environment of care issues.<br><br>* The 4/28/22 GB meeting minutes showed the CNO presented Recruitment/Retention/Turnover. The meeting minutes did not show quality data and analysis reports related to the staffing issues or environment of care issues.<br><br>* The 5/26/22 GB meeting minutes showed a discussion of upcoming union bargaining and | A 315 | | |

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| A 315 | Continued From page 17<br>staffing challenges. The meeting minutes did not show quality data and analysis reports related to the staffing issues or environment of care issues.<br><br>* The 6/23/22 GB meeting minutes did not show discussion of the staffing issues or environment of care issues.<br><br>* The 7/28/22 GB meeting minutes showed in part, "CEO update...main focus/priority = Staffing, plan for local contracts for traveler RNs, current contract not providing staff in a timely manner and recruitment and retention for permanent staff and currently bargaining..." The ACTION section/column showed, "Closed." The meeting minutes did not show the environment of care issues were discussed.<br><br>* The 8/25/22 GB meeting minutes showed most of the meeting addressed the Governing Boards roles and responsibilities. The meeting minutes showed, "Our ultimate goal as a Board is to assure that the hospital is providing the highest quality of care we possibly can." The meeting minutes also showed the following:<br><br>- Board did not feel that [Name of Corporation] Healthcare was investing the money that was needed at this hospital causing huge amounts of frustration. Our nurses were being paid significantly lower than all other facilities in the area.<br><br>- The following questions and comments were raised:<br><br>Q. What could they do to make their day-to-day operations run better, how were they going to get more nurses and when? Could they import | A 315 | | |

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| A 315 | Continued From page 18<br>nurses from other countries?<br><br>A. Years ago, they used to do this, and they could, but this strategy would take many months to put into place. They had a private nursing company that they were working with. Looking at a plan to augment LVNs into the nurse patio ratio which lead into a discussion about the nurse-to-patient ratio making it clear that they were not the only facility going through this and they were by far not the worst.<br><br>Q. How did they get [name of corporation] to free up the reigns and help them get nurses from other sources?<br><br>A. The plan that included a grid of what was needed at [name of hospital] and submitted weekly to corporate. They had 83 travelers in house with 19 future and 36 open. It was difficult now because all of the hospitals were short on nurses. They had recently hired 26 new nurses, not travelers. They were constantly working on recruiting nurses. Pay scales at the local hospitals and our sister hospitals were discussed. It was the consensus of the board that the hospital was in crisis management now and the corporate offices needed to step in and do something before we lost more nurses.<br><br>* The 9/22/22 GB meeting minutes (not yet approved by the GB) showed the staffing statistics were discussed. The CNO reported there had been 600 plus calls to the CDPH from July 9th through September 2nd, 2022 regarding staffing and HVAC issues. Most of the complaints were "regarding out of ratio which have not been substantiated." | A 315 | | |

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| A 315 | Continued From page 19<br>An interview with the members of the GB was conducted on 10/21/22 at 1111 hours. The Chief of Staff stated the GB was aware of the staffing challenges in the hospital and it was an ongoing issue since the COVID-19 pandemic. The Chief of Staff stated they "speak about this daily." The ongoing efforts were discussed and examples included recruitment, retention, registry nurses, and reaching out to corporate as needed. When asked if the GB was aware of the environment of care issues, the Chief of Staff stated the environment of care issues were also ongoing and discussed in the GB meetings.<br><br>On 10/21/22, at 1419 hours, an interview and concurrent review of the GB meeting minutes for March, April, May, June, July, August, and September 2022, was conducted with the CNO (over a telephone), Quality Director, and Manager of Quality Services regarding staffing issues including the efforts to maintain the hospital nurse-to-patient ratios. The CNO stated the staffing issues were reported to the Medical Executive meetings and GB.<br><br>The GB meeting minutes findings were shared with the CNO, Quality Director, and the Manager of Quality Services. The GB minutes did not reflect that staffing issues for the ICU/CCU, NICU, PICU, DOU, 3 EAST, 4 EAST, TELE, 2 EAST, SURG, MBCU, PEDS, and ED were being tracked and monitored, and there was no recommendations or actions documented by the GB in the minutes. In addition, the GB meeting minutes did not reflect the environment of care issues and showed no recommendations or actions documented by the GB in the minutes. | A 315 | | |
| A 385 | NURSING SERVICES | A 385 | | |

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| A 385 | Continued From page 20<br>CFR(s): 482.23<br><br>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.<br><br>This CONDITION is not met as evidenced by:<br>Based on observation, interview, and record review, the hospital failed to have an effective, organized nursing service to provide quality care to the patients as evidenced by:<br><br>1. Failure to ensure sufficient staffing in the ICU/CCU, NICU, PICU, DOU, 3 EAST, 4 EAST, TELE, 2 EAST, SURG, MBCU, PEDS, and ED as evidenced by not maintaining the nurse-to-patient ratios as required. Cross reference to A392.<br><br>2. Failure to ensure the RN supervision and evaluation of the nursing care provided. Cross reference to A395.<br><br>3. Failure to ensure the nursing staff developed individualized nursing care plan. Cross reference to A396.<br><br>4. Failure to ensure the hospital's P&P for patient care was implemented. Cross reference to A398.<br><br>5. Failure to ensure the blood transfusion was administered to the patients as per the hospital's P&P and the physician's ordered. Cross reference to A410.<br><br>The cumulative effect of these systemic failures resulted in the hospital's inability to provide quality healthcare in a safe environment to the patients. | A 385 | | |

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| A 392 | Continued From page 21 | A 392 | | |
| A 392 | STAFFING AND DELIVERY OF CARE<br>CFR(s): 482.23(b)<br><br>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 care of any patient.<br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the hospital failed to ensure the adequate numbers of nursing staff to provide nursing care to the patients as evidenced by:<br><br>1. Failure to maintain the nurse-to-patient ratio for ICU/CCU, NICU, and PICU as required.<br><br>2. Failure to maintain the nurse-to-patient ratio for DOU as required.<br><br>3. Failure to maintain the nurse-to-patient ratio for 3 EAST, 4 EAST, and TELE units as required.<br><br>4. Failure to maintain the nurse-to-patient ratio for 2 EAST and SURG units as required.<br><br>5. Failure to maintain the nurse-to-patient ratio for MBCU as required.<br><br>6. Failure to maintain the nurse-to-patient ratio for PEDS as required.<br><br>7. Failure to maintain the nurse-to-patient ratio for the ED as required.<br><br>8. Failure to ensure the charge nurse was | A 392 | | |

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| A 392 | Continued From page 22<br>assigned for the inpatient units as per the hospital's P&P.<br><br>9. Failure to implement and document the nurse staffing capacity management interventions as per the hospital's P&P.<br><br>10. Failure to implement the corrective plan to ensure the nurse-to-patient ratio was maintained.<br><br>These failures had the increased potential of patient care being compromised, adverse events, inferior clinical outcomes, inpatient deaths, and poorer patient experience of care.<br><br>Findings:<br><br>On 10/12/22 at 1200 hours, an unannounced visit to the hospital was conducted in response to the Department receiving the complaints alleging the hospital was not maintaining the nurse-to-patient ratios at all times as required in ICU/CCU, NICU, PICU, DOU, 3 EAST, 4 EAST, TELE, 2 EAST, SURG, MBCU, and PEDS units for August and September 2022.<br><br>Review of the hospital's P&P titled Plan for Provision of Patient Care and Services dated 7/23/21, showed in part:<br><br>* The Purpose Statement section of the Staffing Plan section showed the following:<br><br>- The nursing division is committed to ensuring adequate staffing to meet the needs of patients and their families entering [Name of Facility].<br><br>- Criteria that is used in reviewing staff needs include patient census, patient acuity and | A 392 | | |

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| A 392 | Continued From page 23<br>complexity of patient's condition, State of California mandated nurse: patient ratios, required nursing care needs, continuity of care needs, skills of the individual registered nurse, technology required, the environment (infection control issues, safety, etc.), unit geography, and availability of support staff.<br><br>- Daily and shift staffing are adjusted based on assessment of patient acuity and staffing guidelines, staffing will at minimum comply with State of California nurse: patient ratios.<br><br>- Staffing is sufficient to assure prompt recognition of any untoward change in a patient's condition and to facilitate appropriate intervention.<br><br>* The areas where nursing is practiced, include acute inpatient areas and ED. The hospital's patient care areas include ICU, NICU, PICU, DOU, telemetry (3 EAST), Telemetry/Oncology (4 EAST), Telemetry (TELE), Pulmonary Medical Unit (2 EAST), Surgical/Orthopedic (SURG), OBCU (MBCU), Pediatrics (PEDS), and ED.<br><br>1. The California Code of Regulations, Title 22, Division 5, Chapter 1, Article 3, §70217, showed the following:<br><br>(a) Hospitals shall provide staffing by licensed nurses, within the scope of their licensure in accordance with the following nurse-to-patient ratios.<br><br>(1) The licensed nurse-to-patient ratio in a critical care unit shall be 1:2 or fewer at all times. "Critical care unit" means a nursing unit of a general acute care hospital which provides one of the following services: an intensive care service, | A 392 | | |

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| A 392 | Continued From page 24<br>a burn center, a coronary care service, an acute respiratory service, or an intensive care newborn nursery service. In the intensive care newborn nursery service, the ratio shall be 1 registered nurse: 2 or fewer patients at all times.<br><br>a. Review of the hospital's documents showed the hospital failed to maintain the nurse-to-patient ratios as required for ICU/CCU on 08/04/22 (for 1 RN noc shift).<br><br>Review of the hospital's document titled [Corporate Name] Ratio Non-Compliance by Hour from 9/1/22 to 9/30/22, showed the nurse-to-patient ratio required for the ICU/CCU was 1:2 (one nurse to two patients). Further review showed the ICU/CCU had the nurse-to-patient out of ratio for 12 of 60 shifts or had 20 Non-Compliant Hours.<br><br>On 10/13/22 at 1620 hours, the Manager of Quality Service confirmed the findings.<br><br>b. Review of the hospital's document titled [Corporate Name] Ratio Non-Compliance by Hour from 9/1/22 to 9/30/22, showed the nurse-to-patient ratio required for the NICU was 1:2. Further review showed the NICU had the nurse-to-patient out of ratio for four of 60 shifts or had seven Non-Compliant Hours.<br><br>Review of the hospital's documents showed the hospital failed to maintain the nurse-to-patient ratios as required for the NICU on 8/07/22 (for one RN day shift) and 10/06/22 (for two RNs noc shift).<br><br>On 10/14/22 at 1120 hours, the Director of NICU, Manager of Quality Services, L&D Manager were | A 392 | | |

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| A 392 | Continued From page 25<br>interviewed and asked to confirm if the units had maintained the required nurse-to-patient ratio for September 2022 through 10/13/22. The Director of NICU stated one RN could be assigned to care for two NICU patients; and the nurse-to-patient ratio could increase as one RN could be assigned to care for up to three NICU patients when the patient was a "feeder grower." The Manager of Quality Services confirmed the hospital did not have an approval program flexibility related to staffing ratio, especially the NICU staffing.<br><br>c. Review of the hospital's document titled [Corporate Name] Ratio Non-Compliance by Hour from 9/1/22 to 9/30/22, showed the nurse-to-patient ratio required for the PICU was 1:2. Further review showed the PICU had the nurse-to-patient out of ratio for 12 out of 60 shifts or had 19 Non-Compliant Hours.<br><br>On 10/13/22 at 1620 hours, the Manager of Quality Service confirmed the findings.<br><br>On 10/14/22 at 0938 hours, an interview and concurrent review of the Nurse Staffing Capacity Management Interventions for September and October 2022 was conducted with the Staffing Office Manager, Director of Telemetry, and Quality Director. The Staffing Office Manager was asked to provide the dates the hospital had not maintained the nurse-to-patient ratio for September and October 2022. The Staffing Office Manager stated the dates the hospital had not maintained the nurse-to-patient ratio, included the following:<br><br>* Day Shift: 9/28 (ICU) and 9/30/22 (PICU)<br><br>* Night Shift: 9/26 (PICU) and 10/12/22 (ICU). | A 392 | | |

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| A 392 | Continued From page 26<br><br>2. The California Code of Regulations, Title 22, Division 5, Chapter 1, Article 3, §70217, showed the following:<br><br>(a) Hospitals shall provide staffing by licensed nurses, within the scope of their licensure in accordance with the following nurse-to-patient ratios.<br><br>(9) The licensed nurse-to-patient ratio in a step-down unit shall be 1:3 or fewer at all times.<br><br>Review of the hospital's documents showed the hospital failed to maintain the nurse-to-patient ratios as required for DOU as following:<br><br>- 08/15/22: 2 RNs day<br>- 10/01/22: 3 RNs day<br>- 10/08/22: 1 RN day<br>- 10/19/22: 2 RNs day<br>- 10/02/22: 5 RNs noc<br>- 10/08/22: 2 RNs noc<br>- 10/12/22: 3 RNs noc<br><br>Review of the hospital's document titled [Corporate Name] Ratio Non-Compliance by Hour from 9/1/22 to 9/30/22, showed the nurse-to-patient ratio required for DOU was 1:3. Further review showed the DOU had the nurse-to-patient out of ratio for 16 out of 60 shifts or had 43 Non-Compliant Hours.<br><br>On 10/13/22 at 1620 hours, the Manager of Quality Service confirmed the findings.<br><br>On 10/14/22 at 0938 hours, an interview and concurrent review of the Nurse Staffing Capacity Management Interventions for September 2022 | A 392 | | |

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| A 392 | Continued From page 27<br>was conducted with the Staffing Office Manager, Director of Telemetry, and Quality Director. The Staffing Office Manager was asked to provide the dates the hospital had not maintained the nurse-to-patient ratio for September 2022. The Staffing Office Manager stated the dates the hospital had not maintained the nurse-to-patient ratio for DOU, included the following:<br><br>* Day Shift: 9/1, 9/2, 9/13, and 9/14/22.<br><br>* Night Shift: 9/5/22.<br><br>On 10/14/22 at 1212 hours, the Director of ICU and DOU was interviewed and asked to confirm if the DOU had maintained the nurse-to-patient ratio for September 2022 through 10/13/22. The Director of ICU and DOU stated the DOU had not maintained the nurse-to-patient ratio on the following date:<br><br>* 09/06/22, noc shift: 1 RN had four patients.<br>* 09/25/22, noc shift: 3 RNs had four patients each.<br>* 09/24/22, noc shift: 4 RNs had four patients each.<br><br>3. The California Code of Regulations, Title 22, Division 5, Chapter 1, Article 3, §70217, showed the following:<br><br>(a) Hospitals shall provide staffing by licensed nurses, within the scope of their licensure in accordance with the following nurse-to-patient ratios.<br><br>(10) The licensed nurse-to-patient ratio in a telemetry unit shall be 1:4 or fewer at all times. | A 392 | | |

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| A 392 | Continued From page 28<br>a. Review of the hospital's documents showed the hospital failed to maintain the nurse-to-patient ratios as required for 3 EAST as following:<br><br>- 08/15/22: 4 RNs day<br>- 08/20/22: 3 RNs day<br><br>Review of the hospital's document titled [Corporate Name] Ratio Non-Compliance by Hour from 9/1/22 to 9/30/22, showed the nurse-to-patient ratio required for 3 EAST was 1:4. Further reviewed showed 3 EAST had the nurse-to-patient out of ratio for 17 out of 60 shifts or had 37 Non-Compliant Hours.<br><br>On 10/13/22 at 1620 hours, the Manager of Quality Service confirmed the findings.<br><br>b. Review of the hospital's documents showed the hospital failed to maintain the nurse-to-patient ratios as required for 4 EAST as following:<br><br>- 08/24/22: 3 RNs day<br>- 10/06/22: 3 RNs day<br>- 10/07/22: 4 RNs noc<br>- 10/08/22: 3 RNs noc<br>- 10/09/22: 4 RNs noc<br><br>Review of the hospital's document titled [Corporate Name] Ratio Non-Compliance by Hour from 9/1/22 to 9/30/22, showed the nurse-to-patient ratio required for 4 EAST was 1:4. Further reviewed showed 4 EAST had the nurse-to-patient out of ratio for 11 out of 60 shifts or had 42 Non-Compliant Hours.<br><br>On 10/13/22 at 1620 hours, the Manager of Quality Service confirmed the findings. | A 392 | | |

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| A 392 | Continued From page 29<br>c. Review of the hospital's documents showed the hospital failed to maintain the nurse-to-patient ratios as required for TELE:<br><br>- 08/03/22: 7 RNs day<br>- 08/19/22: 2 RNs day<br>- 08/24/22: 6 RNs day<br>- 08/26/22: 1 RN day<br>- 08/28/22: 5 RNs day<br>- 10/02/22: 5 RNs day<br>- 10/09/22: 2 RNs noc<br><br>Review of the hospital's document titled [Corporate Name] Ratio Non-Compliance by Hour from 9/1/22 to 9/30/22, showed the nurse-to-patient ratio required for TELE was 1:4. Further reviewed showed TELE had the nurse-to-patient out of ratio for 28 out of 60 shifts or had 88 Non-Compliant Hours.<br><br>On 10/13/22 at 1620 hours, the Manager of Quality Service confirmed the findings.<br><br>On 10/14/22 at 0938 hours, an interview and concurrent review of the Nurse Staffing Capacity Management Interventions for September 2022 was conducted with the Staffing Office Manager, Director of Telemetry, and Quality Director. The Staffing Office Manager was asked to provide the dates the hospital had not maintained the nurse-to-patient ratio for September 2022. The Staffing Office Manager stated the dates the hospital had not maintained the nurse-to-patient ratio included the following:<br><br>* Day Shift: 9/6 (TELE), 9/8 (3 EAST and TELE), 9/9 (TELE), 9/13 (TELE), 9/15 (TELE), 9/17 (3 EAST), 9/24 (TELE), 9/25 (TELE and 3 EAST); 9/26 (TELE), 9/28 (TELE), and 9/30/22 (TELE, 3 | A 392 | | |

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| A 392 | Continued From page 30<br>EAST, and 4 EAST)<br><br>* Night Shift: 9/6 (4 EAST).<br><br>4. The California Code of Regulations, Title 22, Division 5, Chapter 1, Article 3, §70217, showed the following:<br><br>(a) Hospitals shall provide staffing by licensed nurses, within the scope of their licensure in accordance with the following nurse-to-patient ratios.<br><br>(11) The licensed nurse-to-patient ratio in medical/surgical care units shall be 1:5 or fewer at all times.<br><br>a. Review of the hospital's documents showed the hospital failed to maintain the nurse-to-patient ratios as required for 2 EAST as following:<br><br>- 08/03/22: 5 RNs day<br>- 08/22/22: 5 RNs noc<br>- 10/08/22: 2 RNs noc<br>- 10/09/22: 2 RNs noc<br><br>Review of the hospital's document titled [Corporate Name] Ratio Non-Compliance by Hour from 9/1/22 to 9/30/22, showed the nurse-to-patient ratio required for 2 EAST was 1:5. Further reviewed showed 2 EAST had the nurse-to-patient out of ratio for 13 out of 60 shifts or had 40 Non-Compliant Hours.<br><br>On 10/13/22 at 1620 hours, the Manager of Quality Service confirmed the findings.<br><br>b. Review of the hospital's documents showed the hospital failed to maintain the nurse-to-patient | A 392 | | |

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| A 392 | Continued From page 31<br>ratios as required for SURG unit as following:<br><br>- 10/08/22: 3 RNs day<br>- 10/08/22: 1 RN noc<br><br>Review of the hospital's document titled [Corporate Name] Ratio Non-Compliance by Hour from 9/1/22 to 9/30/22, showed the nurse-to-patient ratio required for SURG unit was 1:5. Further reviewed showed SURG had the nurse-to-patient out for 15 out of 60 shifts or had 39 Non-Compliant Hours.<br><br>On 10/13/22 at 1620 hours, the Manager of Quality Service confirmed the findings.<br><br>On 10/14/22 at 0938 hours, an interview and concurrent review of the Nurse Staffing Capacity Management Interventions for September 2022 was conducted with the Staffing Office Manager, Director of Telemetry, and Quality Director. The Staffing Office Manager was asked to provide the dates the hospital had not maintained the nurse-to-patient ratio for September 2022. The Staffing Office Manager stated the dates the hospital had not maintained the nurse-to-patient ratio included the following:<br><br>* Day Shift: 9/17 (2 EAST), 9/25 (2 EAST), and 9/30/22 (2 EAST and SURG)<br><br>5. The California Code of Regulations, Title 22, Division 5, Chapter 1, Article 3, §70217, showed the following:<br><br>(a) Hospitals shall provide staffing by licensed nurses, within the scope of their licensure in accordance with the following nurse-to-patient ratios. | A 392 | | |

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| A 392 | Continued From page 32<br><br>(4) The licensed nurse-to-patient ratio in a postpartum area of the perinatal service shall be 1:4 mother-baby couplets or fewer at all times. In the event of multiple births, the total number of mothers plus infants assigned to a single licensed nurse shall never exceed eight. For postpartum areas in which the licensed nurse's assignment consists of mothers only, the licensed nurse-to-patient ratio shall be 1:6 or fewer at all times.<br><br>Review of the hospital's document titled [Corporate Name] Ratio Non-Compliance by Hour from 9/1/22 to 9/30/22, showed the nurse-to-patient ratio required for MBCU was 1:8. Further review showed the MBCU had the nurse-to-patient out of ratio for one out of 60 shifts or had one Non-Compliant Hour.<br><br>On 10/13/22 at 1620 hours, the Manager of Quality Service confirmed the findings.<br><br>6. The California Code of Regulations, Title 22, Division 5, Chapter 1, Article 3, §70217, showed the following:<br><br>(a) Hospitals shall provide staffing by licensed nurses, within the scope of their licensure in accordance with the following nurse-to-patient ratios.<br><br>(6) The licensed nurse-to-patient ratio in a pediatric service unit shall be 1:4 or fewer at all times.<br><br>Review of the hospital's document titled [Corporate Name] Ratio Non-Compliance by Hour from 9/1/22 to 9/30/22, showed the | A 392 | | |

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| A 392 | Continued From page 33<br>nurse-to-patient ratio required for PEDS unit was 1:4. Further review showed the PEDS unit had the nurse-to-patient out of ratio for two out of 60 shifts or had two Non-Compliant Hours.<br><br>On 10/13/22 at 1620 hours, the Manager of Quality Service confirmed the findings.<br><br>On 10/14/22 at 0938 hours, an interview and concurrent review of the Nurse Staffing Capacity Management Interventions for September 2022 was conducted with the Staffing Office Manager, Director of Telemetry, and Quality Director. The Staffing Office Manager was asked to provide the dates the hospital had not maintained the nurse-to-patient ratio for September 2022. The Staffing Office Manager stated the dates the hospital had not maintained the nurse-to-patient ratio for PEDS unit on 9/26/22, night shift.<br><br>7. The California Code of Regulations, Title 22, Division 5, Chapter 1, Article 3, §70217, showed the following:<br><br>(a) Hospitals shall provide staffing by licensed nurses, within the scope of their licensure in accordance with the following nurse-to-patient ratios.<br><br>(8) The licensed nurse-to-patient ratio in an emergency department shall be 1:4 or fewer at all times.<br><br>Review of the hospital's documents showed the hospital failed to maintain the nurse-to-patient ratios as required for the ED on 10/15/22, night shift for one RN.<br><br>On 10/21/22 at 1530 hours, the Manager of | A 392 | | |

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| A 392 | Continued From page 34<br>Quality Services confirmed RN 1 had been assigned for four patients including one patient with the DOU level of care.<br><br>8. Review of the hospital's P&P titled Patient Classification System (Optilink PCSS) dated 4/29/22, showed in part:<br><br>* The purpose is to provide a systematic method for evaluating a patient's condition and predicting the number and types of resources (skill mix) required to meet those needs.<br><br>* It is the policy of the hospital that RNs will assess and record the acuity of the patients on the unit every shift. This information will be used to staff the oncoming shift and make appropriate patient assignments.<br><br>* The procedures include the following:<br><br>- Patient Assignment: The charge nurse will review the current patient acuity ratings and make appropriate adjustments prior to making assignments.<br><br>- Patient Classification: The charge nurse for each shift will be responsible for ensuring that the classifications, assignment, lunch coverage, shift notes, and shift turnover are completed at least (1) hour before the start of the next shift. At the time of classification, the charge nurse will review the proposed acuities, thus servicing as the expert nurse reviewer. All differences in judgement will be discussed at the time and the agreed upon classification will be entered into PCSS by the charge nurse. If there is significant variation in the shift's acuity index, the charge nurse will record a shift note confirming that all | A 392 | | |

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| A 392 | Continued From page 35<br>acuities are certified by (2) nurses. If PCSS is not available for data entry, the charge nurse will complete the Patient Classification Downtime Form, so that the data can be added when the system is available. The charge nurse will be responsible for entering the data on the downtime form.<br><br>- Staffing: The charge nurse will project staffing requirements for the next shift at least three (3) hours prior to the end of the current shift. At the end of the shift, the charge nurse will revise the recorded worked hours to accurately reflect the actual number of hours worked on each unit by the assigned staff.<br><br>- Invasive Device Tracking: All patients admitted, transferred, or currently residing on the unit will be assessed for Invasive Devices every shift. Invasive devices will be entered in the system on a shift-by-shift basis by the charge nurse.<br><br>- Shift Reconciliation: The charge nurse will reconcile the accuracy of the patient classification, staff, and assignment information for the current shift. This reconciliation will be performed at the end of the shift.<br><br>- Shift Turnover: The departing charge nurse will complete the shift reconciliation and perform shift turnover no more than one (1) hour before the end of the shift.<br><br>Review of the hospital's document titled ICU/DOU Charge Nurse Role & Responsibilities (undated) showed this is to provide clear expectations to all charge nurses and managers. The list below identifies the roles in assisting the hospital to provide consistency to all of our intensive care | A 392 | | |

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| A 392 | Continued From page 36<br>and direct observation (step-down) staff.<br><br>* Designated CNs: Each unit will have a consistent CN for continuity of patient information and unit awareness.<br><br>* Communication: Lead daily unit huddle every change of shift<br><br>* The CNs are responsible to support the operations of our unit. Each of the CNs is an essential part of the team to assure the continuation of providing quality of care and supporting staff.<br><br>Review of the Nurse Staffing Capacity Management Interventions forms for September and October 2022, showed the following:<br><br>* CNs had been given patient assignments as the following:<br><br>- On 9/1/22 at 0600 hours (DOU, 2 EAST, and SURG units)<br><br>- On 9/2/22 (2 EAST, 3 EAST, TELE, DOU, and ICU units)<br><br>- On 9/5/22 at 1900 hours (2 EAST unit)<br><br>- On 9/8/22 at 1900 hours (DOU, 2 EAST, 3 EAST, and 4 EAST units)<br><br>- On 9/9/22 at 0700 hours (3 EAST, 4 EAST, and TELE units)<br><br>- On 9/13/22 at 0700 hours (2 EAST, 3 EAST, 4 EAST, and TELE units) | A 392 | | |

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| A 392 | Continued From page 37<br>- On 9/24/22 at 0700 hours (2 EAST, 3 EAST, 4 EAST, TELE, and SURG units)<br><br>- On 9/25/22 at 0700 hours (2 EAST, 3 EAST, 4 EAST, SURG, and DOU units) and 1900 hours (2 EAST, 3 EAST, 4 EAST, SURG, DOU, ICU, and TELE units)<br><br>- On 9/26/22 at 0700 hours (2 EAST, 3 EAST, 4 EAST, TELE, and SURG units)<br><br>- On 9/28/22 at 0700 hours (2 EAST, 3 EAST, 4 EAST, and TELE units)<br><br>- On 10/12/22 at 0700 hours (4 EAST unit)<br><br>* The Nurse Staffing Capacity Management Interventions forms did not show the Managers/Directors had been assigned as the charge nurses or patient care duties on 9/1, 9/2, 9/5, 9/8, 9/9, 9/13, 9/24, 9/25, 9/26, 9/28, or 10/12/22.<br><br>The above inpatient units did not have the designated CNs when the CNs had been given the patient assessments and the Managers/Directors had not been assigned as the CNs on 9/1, 9/2, 9/5, 9/8, 9/9, 9/13, 9/24, 9/25, 9/26, 9/28, or 10/12/22.<br><br>On 10/13/22 at 1530 hours, an interview and concurrent review of the hospital's document titled Nurse Staffing Capacity Management Interventions (a blank form) was conducted with the Director of Telemetry. When asked if the Director of Telemetry had been assigned as the charge nurse or taken patient care duties, the Director of Telemetry stated it was not documented by him. The Director of Telemetry | A 392 | | |

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| A 392 | Continued From page 38<br>stated, "hopefully reflected in PCCS."<br><br>On 10/21/22 at 1012 hours, during the QAPI meeting, the nursing leadership team was asked if the inpatient care or nursing units had a CN role description or a checklist of the duties that should be done during the shift, the leadership team stated the units did not have the CN role description or checklist. The Director of ICU and DOU stated the ICU and DOU had a checklist for the CN. When asked how CN duties were completed when there was no designated CN, including on nights and weekends, the Director of Telemetry stated the unit directors/managers would be available to assist, including on nights and weekends. When asked about breaks and meal coverage for the RNs when the unit did not have a designated CN, RN breaker, or a resource RN, the Director of Telemetry stated the RNs could take a short break (e.g., 15 minutes). When asked who would watch over the RN's assigned patients when the RNs would take a short break, the Director of Telemetry stated the RNs on break would "make themselves available."<br><br>9. Review of the hospital's P&P titled Nurse Staffing Plan dated 3/20/20, showed the following:<br><br>* Occasional surges in census require immediate intervention from all available personnel. Should this instance happen, the following activities will take place in the following order:<br><br>- Any employee on call will be called in should their competency match the patient need.<br><br>- An Everbridge page will be sent by the Staffing | A 392 | | |

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| A 392 | Continued From page 39<br>Office to all staff who have "opted in" to receive notification of staffing needs. The time/date and content of this page will be documented in the Staffing Office.<br><br>- A request will be sent to registries for per diem staffing.<br><br>- The charge nurse will be assignment a patient assignment.<br><br>- The manager/director will be assigned charge or patient care duties.<br><br>* All interventions taken will be documented in the Staffing Office by date/time/signature.<br><br>Review of the Nurse Staffing Capacity Management Interventions form (undated) showed "occasional surges in census require immediate intervention from all available personnel. Should this instance happen, the following activities must take place in the order they are listed below:"<br><br>- Any employee on call has been called in, should their competency match the patient need.<br><br>- Everbridge sent to all staff who have "opted in" to receive notification of staffing needs.<br><br>- Request sent to Registries for per diem staffing.<br><br>- Bonus CNO approval - [Name of CNO].<br><br>- Bonus CFO approval - [Name].<br><br>- Charge Nurses given patient assignment. | A 392 | | |

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| A 392 | Continued From page 40<br>- Manager/Director assigned charge or patient care duties.<br><br>- RNs from ancillary departments assigned patient care duties.<br><br>Further review of the Nurse Staffing Capacity Management Interventions form showed the sections to document the time, notes, and printed name/signature.<br><br>On 10/13/22 at 1356 hours, the Quality Director was asked to provide documentation of the efforts exhausted to obtain additional staff. The Quality Director stated the Staffing Office Manager maintained a "master log/spreadsheet." The Quality Director stated the Staffing Office Manager had gone home for the day and the information could not be accessed.<br><br>On 10/13/22 at 1530 hours, an interview and concurrent review of the hospital's Nurse Staffing Capacity Management Interventions form (a blank form) was conducted with the Director of Telemetry who was filling in for the CNO. The Director of Telemetry stated the hospital utilized the Nurse Staffing Capacity Management Interventions form to document the interventions/activities when surges in census occurred. The Director of Telemetry stated the form was used for staffing and in collaboration with "Nursing Leaders."<br><br>On 10/14/22 at 0938 hours, an interview and concurrent review of the Nurse Staffing Capacity Management Interventions for September and October 2022 was conducted with the Staffing Office Manager, Director of Telemetry, and Quality Director. The Staffing Office Manager | A 392 | | |

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| A 392 | Continued From page 41<br>confirmed the Staffing Office maintained documentation of the efforts exhausted to obtain additional staff and to maintain the nurse-to-patient ratio.<br><br>Review of the Nurse Staffing Capacity Management Interventions forms for September and October 2022, showed the following:<br><br>* The forms were not completed its entirety, including the time and the printed name/signature of the staff that had implemented the interventions/activities.<br><br>* The notes column did not show documentation if all the units had been approved for a bonus by the CNO; and if approved, there was no documentation of the units that had been approved for a bonus.<br><br>* The forms did not show that "RNs from ancillary department assigned patient care duties" had been an intervention/activity implemented on 9/1, 9/2, 9/5, 9/9, 9/24, 9/25, 9/26, 9/28, and 10/12/22, as an effort to maintain the nurse-to-patient ratio.<br><br>* The forms did not show that Managers/Directors had been assigned as the charge nurses or patient care duties on 9/1, 9/2, 9/5, 9/8, 9/9, 9/13, 9/24, 9/25, 9/26, 9/28, or 10/12/22, as an effort to maintain the nurse-to-patient ratio.<br><br>On 10/14/22 at 1052 hours, the Surgical Manager was interviewed and asked to confirm if the SURG unit had maintained the nurse-to-patient ratio for September 2022 through 10/13/22. The Surgical Manager stated the SURG unit had maintained the nurse-to-patient ratio for September 2022 through 10/13/22. | A 392 | | |

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| A 392 | Continued From page 42<br><br>On 10/14/22 at 1120 hours, the Director of NICU, and the L&D Manager were interviewed and asked to confirm if the units had maintained the nurse-to-patient ratio for September 2022 through 10/13/22. The Director of NICU and the L&D Manager stated the units had maintained the nurse-to-patient ratio for September 2022 through 10/13/22.<br><br>On 10/14/22 at 1212 hours, the Director of ICU and DOU was interviewed and asked to confirm if the DOU and ICU had maintained the nurse-to-patient ratio for September 2022 through 10/13/22. The Director of ICU and DOU stated the ICU had maintained the nurse-to-patient ratio for September 2022 through 10/13/22.<br><br>However, during a complaint validation survey from 10/12/22 to 10/21/22, the following was identified:<br><br>* The nurse-to-patient ratio was not maintained for ICU/CCU, NICU, PICU as required. Cross reference to A392, example # 1.<br><br>* The nurse-to-patient ratio was not maintained for DOU as required. Cross reference to A392, example # 2.<br><br>* The nurse-to-patient ratio was not maintained for 3 EAST, 4 EAST, and TELE units as required. Cross reference to A392, example # 3.<br><br>* The nurse-to-patient ratio was not maintained for 2 EAST and SURG unit as required. Cross reference to A392, example # 4.<br><br>* The nurse-to-patient ratio was not maintained | A 392 | | |

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| A 392 | Continued From page 43<br>for MBCU as required. Cross reference to A392, example # 5.<br><br>* The nurse-to-patient ratio was not maintained for Pediatric unit as required. Cross reference to A392, example # 6.<br><br>* The nurse-to-patient ratio was not maintained for ED as required. Cross reference to A392, example # 7.<br><br>* There was no documented evidence to show the Managers and/or Directors of the inpatient units were assigned as a charge nurse or patient care duties as an immediate intervention from all available personnel as per the hospital's Nurse Staffing Plan. Cross reference to A392, example # 8.<br><br>10. Review of the hospital's corrective actions for failure to ensure the licensed nurse-to-patient ratio was maintained in the DOU and telemetry unit with the completion date as of 7/19/22, showed the hospital's corrective actions included the following:<br><br>* Place a FT lift employee in CCU to assist with turning, etc.<br><br>* Review elective procedure admissions by the CNO and COO.<br><br>* Continue arrangement with Traveler Agencies for 13 weeks travelers and 4-week rapid deployment Traveler Nurses.<br><br>On 10/21/22 at 1012 hours, during the QAPI meeting, the nursing leadership team was asked to speak to the current plan of correction for the | A 392 | | |

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| A 392 | Continued From page 44<br>units that had not maintained the nurse-to-patient ratio, including the efforts that had "been put in place to stabilize staffing issue."<br><br>a. When asked about the corrective action of placing a lift employee in the critical care unit to assist with turning or repositioning the patients, the Director of ICU and DOU confirmed the critical care unit did not have a lift employee to assist with turning or repositioning the patients on the night shift.<br><br>b. When asked about other efforts to maintain the nurse-to-patient ratios. The nursing leadership confirmed the hospital should cancel elective surgeries.<br><br>c. The hospital was asked to provide utilization data of Rapid Traveler Nurses.<br><br>Review of hospital's document titled AMN Traveler Order dated 9/7/22, showed the traveler order did not specify if the traveler order was for rapid travel nurses. In addition, there was no documents to show traveler nurses were on assignment for the units with historical data of not maintaining the nurse-to-patient ratios, including 2 EAST, 3 EAST, 4 EAST, ICU/CCU, MBCU, NICU, PEDS, SURG, and TELE units.<br><br>On 10/14/22 at 0938 hours, an interview and concurrent review of the Nurse Staffing Capacity Management Interventions for September and October 2022 was conducted with the Staffing Office Manager, Director of Telemetry, and Quality Director. The Staffing Office Manager was asked about the process for ordering Rapid Traveler Nurses, the Staffing Office Manager stated there was a process for the approval to | A 392 | | |

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| A 392 | Continued From page 45<br>utilize them, including approval from the CFO and from Corporate. The Director of Telemetry stated the Rapid Traveler Nurses were "expensive." | A 392 | | |
| A 395 | RN SUPERVISION OF NURSING CARE<br>CFR(s): 482.23(b)(3)<br><br>A registered nurse must supervise and evaluate the nursing care for each patient.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the hospital failed to ensure the RN supervised and evaluated the nursing care for the patients as evidenced by:<br><br>1. Failure to ensure the heart rhythm/rate and audible alarm were verified every four hours for patients who were on telemetry monitoring.<br><br>2. Failure to ensure the nursing staff completed the Constant Observer Flow Sheet form and obtained the order for the level of constant observation from the QMP or QMHP as per the hospital's P&P for one of 17 sampled patients (Patient 9).<br><br>These failures created the increased risk of poor health outcomes to the patients.<br><br>Findings:<br><br>1. Review of the hospital's P&P titled Standards of Nursing Practice: Telemetry dated 4/1/21, showed the EKG strip is obtained and PR, QRS, and QT intervals are documented on admission and the beginning of each shift. The rhythm will be assessed, and the alarms set on admission. The rate and alarms will be assessed and | A 395 | | |

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| A 395 | Continued From page 46<br>documents on admission and each shift. Rate and alarms will be documented every four hours in the central monitor telemetry log.<br><br>Review of the hospital's P&P titled Standards of Care-Definitive Observation Unit (DOU) dated 12/9/21, showed the cardiac evaluation is to be done every four hours and PRN. EKG rhythms are assessed by a RN at the beginning of each shift and reassessed PRN. Appropriate interventions are made when necessary. Alarms for life-threatening rhythms will be on at all times and documented by the RN every shift.<br><br>a. Review of the Central Monitor DOU logs, showed the heart rhythm/rate and audible alarm had not been verified as follows:<br><br>* From 9/1/22 at 0800 hours to 9/2/22 at 0400 hours, at least 30 heart rhythm/rate and audible alarms had not been verified.<br><br>* From 9/2/22 at 0800 hours to 9/3/22 at 0400 hours, 15 heart rhythm/rate and audible alarms had not been verified.<br><br>* From 9/3/22 at 0800 hours to 9/4/22 at 0400 hours, at least 30 heart rhythm/rate and audible alarms had not been verified for.<br><br>* From 9/5/22 at 0800 hours to 9/6/22 at 0400 hours, at least 50 heart rhythm/rate and audible alarms had not been verified for.<br><br>* From 9/14/22 at 0800 hours to 9/15/22 at 0400 hours, at least 80 heart rhythm/rate and audible alarm had not been verified.<br><br>Review of the Cardiac Monitor DOU Log dated | A 395 | | |

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| A 395 | Continued From page 47<br>9/24/22, showed the RN did not sign and date on the "Hand-Off Communication: Verify and document alarm status with every handoff" on 9/24 and 9/25/22.<br><br>On 10/14/22 at 0945 hours, the findings were verified with the Manager of Quality Services.<br><br>b. On 10/18/22 at 1600 hours, a tour of 4 EAST was conducted with the 4 East Manager, Quality Director, and IP Nurse.<br><br>When asked about the P&P for the assessing and documenting the heart rhythm for the patients that were on continuous telemetry monitoring, the 4 EAST Manager stated the heart rhythm would be assessed and documented at 0800, 1200, and 1600 hours during the day shift.<br><br>Review of the Central Monitoring Telemetry Log dated 10/18/22, showed the heart rhythm/rate and audible alarm had not been verified for seven patients at 0800 and for seven patients at 1200 hour.<br><br>The 4 EAST Manager acknowledged the findings.<br><br>2. Review of the hospital's P&P titled Constant Observer for Patients Under Harm Precautions dated 6/15/22, showed the following:<br><br>* A registered nurse will screen the patient's physical condition, behaviors, and emotional status to determine if constant observation of the patient is warranted to ensure patient's safety.<br><br>* After completing a medical screening exam, the level of constant observation is ordered by the QMP or QMHP | A 395 | | |

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| A 395 | Continued From page 48<br><br>* The nurse assigned to the patient remains responsible for the nursing care throughout the shift regardless of the presence of a Competent Constant Observers (CCO).<br><br>On 10/20/22 at 1155 hours, an interview and concurrent review of Patient 9's medical record was conducted with the Manager of Quality Services.<br><br>Patient 9's medical record showed the patient was admitted to the hospital on 8/6/22.<br><br>Review of the restraint flowsheet dated 8/6/22 at 1800 hours, showed Patient 9 was in four-point soft restraints to all extremities and the patient's four siderails were in up position due to combative and uncooperative behavior.<br><br>Review of the Constant Observer Flow Sheet dated 8/6/22, showed the following:<br><br>* The Constant Observer (CO) was assigned to Patient 9 from 8/6/22 at 1600 hours to 8/7/22 at 0645 hours.<br><br>* The "SECTION ONE SIGNATURES: To be completed by the Constant Observer (CO) and Nurse' showed the sections of RN name and RN signature were left blank.<br><br>* The "SECTION TWO: To be completed by the Constant Observer and validated by the nurse every 4 hours" showed there was no documented evidence showing the RN validated the form.<br><br>* There was no documented evidence to show the QMP or QMHP ordered the Constant | A 395 | | |

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| A 395 | Continued From page 49<br>Observer for Patient 9's as per the hospital's P&P.<br><br>Review of the Constant Observer Flow Sheet dated 8/7/22, showed the Constant Observer (CO) was assigned to Patient 9 from 8/7/22 at 0700 hours to 8/8/22 at 0645 hours. However, there was no document to show the QMP or QMHP ordered the Constant Observer for Patient 9 as per the hospital's P&P.<br><br>The Manager of Quality Services confirmed the findings. | A 395 | | |
| A 396 | NURSING CARE PLAN<br>CFR(s): 482.23(b)(4)<br><br>The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient that reflects the patient's goals and the nursing care to be provided to meet the patient's needs. The nursing care plan may be part of an interdisciplinary care plan.<br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the hospital failed to develop and maintain the care plan to address the care needs for two of 17 sampled patients (Patients 5 and 10). This failure posed an increased risk of substandard health outcomes to the patients.<br><br>Findings:<br><br>Review of the hospital's P&P titled Plan of Care, Interdisciplinary dated 12/9/21, showed the following:<br><br>* The RN in partnership with the patient initiates the Interdisciplinary Plan of Care after completion | A 396 | | |

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| A 396 | Continued From page 50<br>of the initial assessment.<br><br>* Assessment, planning, and evaluation are interdisciplinary and are to be documented on the Interdisciplinary Plan of Care or as otherwise indicated in the EMR. The plan is individualized and based upon actual or potential problems, anticipated length of stay, assessed needs, policies, patient care standards, cultural issues, available resources and will be consistent with other therapies and/or disciplines.<br><br>* The Interdisciplinary Plan of Care will be reviewed every shift and updated as patient progress indicates.<br><br>1. Review of the hospital's P&P titled Wound & Skin Care Guidelines, Management & Documentation dated 11/3/20 showed the Wound Care Nurse will be responsible for the development of the overall interdisciplinary plan of care.<br><br>On 10/12/22 at 1315 hours, an interview and concurrent review of Patient 5's medical record review was conducted with the Manager of Quality Services.<br><br>Patient 5's medical record showed the patient was admitted to the hospital on 8/16/22 and discharged on 9/15/22.<br><br>Patient 8 was admitted on 8/16/22 and discharged on 9/15/22. Patient 5's Braden score was 19 on 8/16/22 and decreased to 15 on 8/26/22.<br><br>Review of the physician's order dated 8/26/22 at 1004 hours, showed to assess skin daily, place | A 396 | | |

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| A 396 | Continued From page 51<br>foam dressing over sacrum/coccyx, and change dressing PRN.<br><br>However, there was no problem list for risk of skin impairment developed for Patient 5 until 9/2/22.<br><br>The Manager of Quality Services confirmed the findings.<br><br>2. Review of the hospital's P&P titled Restraint and Seclusion dated 6/15/22, showed the use of restraints must be addressed in the patient's modified plan of care.<br><br>On 10/20/22 at 1130 hours, an interview and concurrent review of Patient 10's medical record was conducted with the Manager of Quality Services.<br><br>Patient 10's medical record showed the patient was admitted to the hospital on 9/18/22 and discharged on 9/29/22.<br><br>Review of the restraint flowsheets showed Patient 10 was placed in two-point soft restraints to the bilateral upper extremities on 9/24/22 at 1000 hours, due to interfering with medical devices. Further review of the restraint flowsheet showed the patient was restrained with two-point soft restraint on 9/24/22 at 1200, 1400, 1600, and 1800 hours; on 9/25/22 at 2000 and 2200 hours; and on 9/26/22 at 0000, 0200, 0400 hours.<br><br>When asked to review Patient 10's care plans to show a problem list addressing the restraints, the Manager of Quality Services stated she was not able to locate a care plan and assumed they were not done; therefore, there were no care plans | A 396 | | |

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| A 396 | Continued From page 52<br>addressing the use of restraint for Patient 10.<br><br>The Manager of Quality Services confirmed the findings. | A 396 | | |
| A 398 | SUPERVISION OF CONTRACT STAFF<br>CFR(s): 482.23(b)(6)<br><br>All licensed nurses who provide services in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of all nursing personnel which occur within the responsibility of the nursing service, regardless of the mechanism through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer).<br>This STANDARD is not met as evidenced by:<br>Based on observation, interview, and record review, the hospital failed to ensure the nursing staff adhered to the hospital's P&Ps as evidenced by:<br><br>1. Failure to ensure the crash carts were checked daily for 4 EAST, MBCU, NICU, PEDS, PICU, ICU, and ED as per the hospital's P&P.<br><br>2. Failure to ensure the nursing staff implemented the hospital's P&P related to the IV administration sets for 13 out of 14 non-sampled patients were labeled with the date the tubing was required to be replaced as per the hospital's P&P.<br><br>3. Failure to ensure the nursing staff implemented the hospital's P&P related to wound and skin care for six of 17 sampled patients (Patients 3, 4, 5, 14, 15, and 16). There was no documented evidence showing the nursing staff | A 398 | | |

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| A 398 | Continued From page 53<br>turned and repositioned Patients 3, 4, 5, 14, 15, and 16 every two hours; completed the photographic documentation of the pressure injuries for Patients 3, 14, and 15; and performed skin assessment for Patients 3, 4, 5, and 15.<br><br>4. Failure to ensure the nursing staff implemented the hospital's P&P related to the use of restraints for three of 17 sampled patients (Patients 9, 10, and 12). There was no documented evidence showing the nursing staff conducted every two hours assessment for Patient 10 and obtained the physician's orders for the use of restraints for Patients 9, 10, and 12.<br><br>These failures had the potential to put the patients at risk for negative health outcomes.<br><br>Findings:<br><br>1. Review of the hospital's P&P titled Emergency Codes - Environment of Care and Medical dated 1/28/22, showed personnel on each unit/department will be assigned daily to check the defibrillator for capability (per manufacturer's directions) and crash cart for all items listed.<br><br>Review of the hospital's P&P titled Standards of Nursing Practice: Telemetry dated 4/1/21, showed in part:<br><br>* The Standard of Nursing Practice outlines the expected levels of performance, promote quality of care, and provide a tool for assessment of quality and performance.<br><br>* Unit Management, Safety and Environment: The crash carts are checked and documented once a day. | A 398 | | |

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| A 398 | Continued From page 54<br><br>a. On 10/17/22 at 1404 hours, a tour of ICU was conducted with the DOU Manager, Quality Director, and Manager of Quality Services.<br><br>Review of the ICU Crash Cart Checklist for September and October 2022 showed the crash cart had not been checked for three shifts in September 2022.<br><br>The DOU Manager confirmed the findings. The DOU Manager stated the CN completed the crash cart check in the DOU; and the CN or the Code Blue RN completed the crash cart check in the ICU.<br><br>b. The Crash Cart Checklists for April through October 2022 were requested and reviewed for all inpatient units. The following was identified:<br><br>* For 4 EAST: there was no documentation showing the crash cart check was completed six shifts.<br><br>* For MBCU: there was no documentation showing the crash cart check was completed for one shift for the adult crash cart.<br><br>* For MBCU: there was no documentation showing the cart check was completed for one shift for the pediatric crash cart.<br><br>* For NICU: there was no documentation showing the emergency cart check was completed for one shift.<br><br>* For PEDS: there was no documentation showing the crash cart check was completed for two shifts for the pediatric crash cart. | A 398 | | |

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| A 398 | Continued From page 55<br><br>* For PEDS: there was no documentation showing the crash cart check was completed for three shifts for the adult crash cart.<br><br>* For PICU: there was no documentation showing the crash cart check was completed for one shift; and there was no documentation showing the crash cart check was completed for 31 shifts in July 2022.<br><br>* For ICU: there was no documentation showing the crash cart check was completed for at least 10 shifts.<br><br>* For ED: there was no documentation showing the crash cart check was completed for at least 70 shifts.<br><br>2. Review of the hospital's P&P titled Clinical Guidelines Venous Access Device Prevention Insertion and Maintenance dated 6/25/21, showed in part:<br><br>* Check for system integrity, infusion accuracy, and expiration dates (infusion, dressing, and administration set) at least every shift.<br><br>* Primary and secondary continuous administration sets:<br><br>- Replace no more frequently than every 96 hours and PRN if compromised.<br><br>- Replace at least every 24 hours for Lipid/TPN administration.<br><br>* The Chief Nursing Officer is responsible for ensuring that all individuals adhere to the | A 398 | | |

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| A 398 | Continued From page 56<br>requirements of this policy, that these procedures are implemented and followed.<br><br>* The Nursing Directors or designee are responsible for daily monitoring of compliance to the guideline.<br><br>a. On 10/20/22 at 0902 hours, a tour of ICU was conducted with the Director of ICU and DOU, Quality Director, and Manager of Quality Services. When asked to explain the hospital's P&P for replacing the IV administrations set, the Director ICU and DOU stated the IV set had to be labeled with a sticker/label and the label had to be dated with the date the IV administration set had to be changed. The Director ICU and DOU further stated the IV administration set had to be changed every 96 hours.<br><br>The IV administration sets for 11 patients were observed with the Director of ICU and DOU. The total of 32 IV administration sets had not been dated with the date the IV administration set had to be changed.<br><br>The Director of ICU and DOU confirmed the total of 32 IV administration sets had not been dated with the date the IV administration set had to be changed.<br><br>b. On 10/20/22 at 1201 hours, a tour of the NICU was conducted with the Director of NICU, Quality Director, and Manager of Quality Services. The IV administration sets for three NICU patients were observed with the bedside nurses and the Quality Directors. Upon inspection of the IV administration sets, three TPN IV administration sets were observed not labeled with the date the IV administration set had to be replaced. | A 398 | | |

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| A 398 | Continued From page 57<br><br>On 10/20/22 at 1201 hours, the Quality Director and Manager of Quality Services acknowledged the findings.<br><br>3. In 2016, the NPUAP (National Pressure Ulcer Advisory Panel) defined the following:<br><br>* A pressure injury (same as ulcer) is defined as a localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device.<br><br>* Stage 3 pressure injury is defined as a full-thickness skin loss in which fat tissue is visible in the ulcer. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location. Undermining and tunneling may occur. The subcutaneous fat may be visible but bone, tendon, or muscle are not exposed.<br><br>* Stage 4 pressure injury is defined as a full-thickness skin and tissue loss with exposed or directly palpable muscle, tendon, ligament, or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an unstageable pressure injury.<br><br>* Unstageable pressure ulcer is defined as obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. | A 398 | | |

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| A 398 | Continued From page 58<br>* Deep Tissue Pressure Injury is defined as persistent non-blanchable deep red, maroon, or purple discoloration. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss.<br><br>Review of the hospital's P&P titled Wound & Skin Care Guidelines, Management & Documentation dated 11/03/20, showed the following:<br><br>* The Admission Tissue Integrity Assessment section showed a complete skin assessment will be performed through four eyes (two Registered Nurses), to detect existing tissue integrity issues and will include, but not be limited to all abrasions, bruises, wounds, pressure ulcers, lesions, petechiae, rashes, scars, and skin tears<br><br>* The Reassessment section showed the following:<br><br>- A complete skin assessment will be performed and documented every shift.<br><br>- The Pressure Ulcer Risk Score will be reassessed and documented with each shift change.<br><br>* The Braden Risk Assessment section showed a Braden score of 18 or below indicates an identified risk for skin breakdown.<br><br>* For patients with wound or with a Braden score of 18 or less, the PUPP will be initiated in the EMR for interventions to manager moisture, pressure, and nutrition.<br><br>* The Pressure Reduction Measures section showed even with adjunct therapy such as a | A 398 | | |

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| A 398 | Continued From page 59<br>specialty surface or device, the patient needs to be turned or repositioned for efficient offloading of pressure areas at least every two hours while in bed or unless contraindicated for patient's care.<br><br>* The Document the Initiated Interventions from the Nursing-Pressure Ulcer Prevention Protocol (PUPP) showed to document the patient's position if the patient unable to self-position.<br><br>* The Photographic Documentation section showed the following:<br><br>- Date, measurement device, and patient identifier must be contained within the frame of the picture.<br><br>- The anatomical location depicted in the photo must be written in the space provided on the form.<br><br>a. On 10/12/22 at 1453 hours, an interview and concurrent review of Patient 14's medical record was conducted with the Quality Director and Manager of Quality Services.<br><br>Patient 14's medical record showed Patient 14 was admitted to the hospital on 8/12/22.<br><br>Review of the Wound Care Note dated 8/24/22 at 1652 hours, showed a wound care consult was received to assess the left buttock wound. Patient 14 was able to reposition himself independently. The patient had a DTI to the left buttock. The plan was to remind the patient to reposition himself in bed and the PUPP protocol was already initiated.<br><br>Review of the Wound Care Note dated 9/1/22 at | A 398 | | |

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| A 398 | Continued From page 60<br>1524 hours, showed the left buttock DTI had deteriorated to an unstageable pressure injury. The plan was to continue to follow the PUPP protocol.<br><br>* Review of the turning and repositioning documentation from 8/30/22 at 0457 hours through 9/2/22 at 0000 hours, showed there was no documentation showing Patient 14 was repositioned by self or staff every two hours as follow:<br><br>- On 8/30/22 at 0700, 0900, 1300, 1800 and 2200 hours.<br><br>- On 8/31/22 at 0630, 0830, 1030, 1230, 1430, 1630 and 1830 hours.<br><br>- On 9/1/22 at 0600, 1000, 1445, 2000 hours.<br><br>There was no documented evidence to show Patient 14 had refused to reposition himself in bed.<br><br>* Review of the Photographic Wound/Skin Documentation for the left buttock dated 8/22, 8/24, 9/1, and 9/7/22, showed the following:<br><br>- On 8/22/22, the date and measurement device were not contained within the frame of the picture.<br><br>- On 8/24, 9/1, and 9/7/22, the date was not contained within the frame of the picture.<br><br>The Quality Director and Manager of Quality Services confirmed the findings.<br><br>b. On 10/12/22 at 1200 hours, an interview and | A 398 | | |

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| A 398 | Continued From page 61<br>concurrent review of Patient 15's medical record was conducted with the Quality Director and Manager of Quality Services.<br><br>Patient 15's medical record showed Patient 15 was admitted to the hospital on 6/28/22.<br><br>Review of the Wound Care Note dated 9/13/22 at 1118 hours, showed Patient 15 had limited bed mobility due to hip dislocation and required moderate assistance to reposition to the sides. The patient's Braden score was 16. The patient had an unstageable pressure injury to the right heel. The plan was to continue the PUPP protocol.<br><br>* Review of the turning and repositioning flowsheet from 9/10/22 at 0055 hours through 9/13/22 at 2230 hours, showed there was no documentation showing Patient 15 was repositioned every two hours as follow:<br><br>- On 9/10/22 at 0300 and 1130 hours.<br><br>- On 9/11/22 at 0000, 0200, 0400, and 0600 hours.<br><br>- On 9/12/22 at 0600 hours<br><br>- On 9/13/22 at 0000, 0200, 0400, 0800, 1300, 1630, 1830, and 2030 hours.<br><br>* Review of the Photographic Wound/Skin Documentation of right heel showed the following:<br><br>- On 6/30/22, the date and measurement device were not contained within the frame of the pictures and the patient identifier was blurry on one of the photos. | A 398 | | |

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| A 398 | Continued From page 62<br><br>- On 7/6, 8/10, 8/17, 8/26, 9/5, and 9/7/22, the date was not contained within the frame of the picture.<br><br>- On 8/18, 8/31, 9/14, and 9/21/22, the date was not contained within the frame of the picture and the patient identifier was blurry and not legible.<br><br>* Review of the Integumentary documentation did not show documentation a skin assessment was performed for Patient 15 on 9/11 (day shift) and 9/12/22 (day and night shifts).<br><br>c. On 10/20/22 at 1622 hours, an interview and concurrent review of Patient 16's medical record was conducted with the Manager of Quality Services.<br><br>Patient 16's medical record showed Patient 16 was admitted to the hospital on 10/15/22, with metastatic prostate cancer and paralysis.<br><br>Review of the Braden Assessment dated 10/15/22, showed Patient 16 had been identified at a risk for skin breakdown. The patient's Braden score was 18.<br><br>Review of the Wound Care dated 10/16/22, showed Patient 16 had an unstageable pressure injury to the right ankle that was present on arrival to the hospital.<br><br>Review of the turning and repositioning flowsheet from 10/16/22 at 1600 hours through 10/19/22 at 1027 hours, showed there was no documentation showing Patient 16 was repositioned every two hours as follow: | A 398 | | |

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| A 398 | Continued From page 63<br>- On 10/16/22 at 1800, 2000, and 2200 hours.<br><br>- On 10/17/22 at 0000, 0200, 0400, and 0600 hours.<br><br>- On 10/18/22 at 1000, 1200, 1400, 1600, 1800, and 2200 hours.<br><br>- On 10/19/22 at 0700, and 0900 hours.<br><br>The Manager of Quality Services confirmed the findings.<br><br>d. On 10/12/22 at 1315 hours, an interview and concurrent review of Patient 5's medical record was conducted with the Manager of Quality Services.<br><br>Patient 5's medical record showed the patient was admitted to the hospital on 8/16/22.<br><br>Review of the physician's order dated 8/25/22 at 0728 hours, showed to turn Patient 5 every two hours, assist with turning, or verbally prompt the patient to reposition.<br><br>* Review of the turning and repositioning flowsheets showed Patient 5 was not turned on the following dates and times:<br><br>- On 8/26/22 at 1600 and 1800 hours.<br><br>- On 8/28/22 at 0600 hours.<br><br>- On 9/4/22 at 0600 hours.<br><br>- On 9/6/22 at 0600 hours.<br><br>- On 9/7/22 at 1600 hours. | A 398 | | |

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| A 398 | Continued From page 64<br><br>- On 9/10/22 at 1400, 1600, and 1800 hours.<br><br>- On 9/11/22 at 1800 hours.<br><br>The Manger of Quality Services confirmed the findings.<br><br>* The Manger of Quality Services was asked to provide the nursing skin assessments for Patient 5, but none were provided to show skin assessments performed every shift as per the hospital's P&P. The Manager of Quality Services stated she would try and find them. However, there was no documents provided.<br><br>e. On 10/13/22 at 0940 hours, an interview and concurrent review of Patient 3's medical record was conducted with the Manager of Quality Services.<br><br>Patient 3's medical record showed the patient was admitted to the hospital on 8/31/22.<br><br>Review of the Integumentary showed Patient 3's Braden score was 14 on 8/31/22 at 1400 hours.<br><br>Review of the Wound Care Note dated 9/2/22 at 1455 hours, showed Patient 3 was admitted with a DTI to the sacral area. The plan showed the PUPP protocol was initiated; the nurses were to reposition patient frequently; for each incontinence episode, the nurses were to perform hygiene care, pat dry, and apply barrier cream; the nurses were to clean sacral DTI with normal saline or wound cleanser and monitor for further skin breakdown.<br><br>* Review of the turning and reposition flowsheets | A 398 | | |

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| A 398 | Continued From page 65<br>showed Patient 3 was able to turn self at times but was also being assisted by nursing staff.<br><br>Further review of the turning and reposition flowsheet showed Patient 3 did not turn self or was not assisted with repositioning on 9/3/22 from 0840 to 1300 hour (or approximately four hours), 9/4/22 from 0000 to 0800 hours (or eight hours), 9/5/22 from 0000 to 1047 hours (or approximately 10 hours), and 9/10/22 from 1418 hours to 1936 hours (or approximately 5 hours).<br><br>* Review of the Photographic Wound/Skin Documentation showed two pictures of patient's pressure injuries had no nurses' signatures, dates, or location of the patient's pressure injuries.<br><br>* The Manager of Quality Services was asked to provide skin assessments for Patient 3. The Manager of Quality Services stated she was not able to find documentation showing Patient 3's skin assessments were completed on 9/4 and 9/5/22.<br><br>The Manager of Quality Services confirmed the findings.<br><br>f. On 10/13/22 at 1500 hours, an interview and concurrent review of Patient 4's medical record was conducted with the Manager of Quality Services.<br><br>Patient 4's medical record showed the patient was admitted to the hospital on 9/2/22.<br><br>Review of the Braden Assessment section showed Patient 4's Braden score was 12 on 9/2/22 at 2000 hours. | A 398 | | |

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| A 398 | Continued From page 66<br><br>* Review of the turning and repositioning flowsheets showed Patient 4 was not turned or reposition every two hours as follow:<br><br>- On 9/3/22 at 0600 hours.<br><br>- On 9/4/22 at 0600 hours.<br><br>- On 9/15/22 at 0200 and 0600 hours.<br><br>- On 9/25/22 at 0600 hours.<br><br>- On 10/3/22 at 0400 and 0600 hours.<br><br>- On 10/4/22 at 0600 hours.<br><br>* Review of Patient 4's skin assessments showed the nursing staff did not perform an initial skin assessment for the patient. When asked for documentation of skin assessments, the Manager of Quality Services stated she was unable to find any flowsheets or nursing documentation to show skin assessments were performed.<br><br>4. Review of the hospital's P&P titled Restraint & Seclusion dated 6/15/22, showed in part:<br><br>* Based on an individualized patient assessment and re-evaluation, the use of restraints and seclusion is limited to those situations where it is necessary to ensure the immediate physical safety of the patient, staff members, or others.<br><br>* RN assessments are documented on the Restraint Flowsheet following the Observation Monitoring guidelines. | A 398 | | |

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| A 398 | Continued From page 67<br>* Restraints is initiated or continued only upon the order of a physician or LIP, following the procedure guidelines in Exhibit A.<br><br>* Each episode of restraint use shall be documented in the patient's medical record, and shall include but not be limited to:<br><br>- Assessment and reassessment.<br><br>- Relevant orders for use of restraints.<br><br>- Results of patient monitoring will occur following the procedural guideline in Exhibit A.<br><br>- Use of restraints must be addressed in the patient's modified plan of care.<br><br>- Discontinuation of restraint at earliest possible time.<br><br>* The Exhibit A- Restraint or Seclusion Procedural Guidelines section showed the following:<br><br>- In an emergent situation, and when a physician or LIP is not readily available, a Registered Nurse competent in restraint usage may initiate restraint use based on an appropriate assessment of patient needs.<br><br>- The order must be obtained either during the emergency application of the Restraint or immediately (defined as without time interval) after the restraint has been applied.<br><br>- Restraint orders must be renewed on a daily basis.<br><br>- When restraint or seclusion is used, there must | A 398 | | |

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| A 398 | Continued From page 68 | A 398 | | |

be documentation in the patient's medical record of the description of the patient's behavior and the intervention used. A patient in three- or four-point restraints shall have continuous observation/monitoring according to the Constant Observer Policy.

* For Non-Violent or Medical Support Restraint Track, the registered nurse re-assesses the restraint and documents at two-hour intervals.

a. On 10/20/22 at 1130 hours, an interview and review of Patient 10's medical record was conducted with the Manager of Quality Services.

Patient 10's medical record showed the patient was admitted to the hospital on 9/18/22 and discharged on 9/29/22.

Review of the physician's order dated 9/24/22 at 1932 hours, showed to apply two-point soft restraints to the bilateral upper extremities as the non-violent restraint.

Review of the restraint flowsheets showed Patient 10 was placed in two-point soft restraints to the bilateral upper extremities on 9/24/22 at 1000 hours, due to interfering with medical devices. Further review of the restraint flowsheet showed the patient was restrained with two-point soft restraint on 9/24/22 at 1200, 1400, 1600, and 1800 hours; on 9/25/22 at 2000 and 2200 hours; and on 9/26/22 at 0000, 0200, 0400 hours. There was no documented evidence to show the nursing staff assessed the patient every two hours as per the hospital's P&P, from 9/24/22 at 1800 hours to 9/25/22 at 2000 hours. There was no documentation to show the nursing staff obtained the physician's order for the use of

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restraint when Patient 10 was restrained on 9/25/22.

The Manager of Quality Services confirmed the findings.

b. On 10/20/22 at 1155 hours, an interview and concurrent review of Patient 9's medical record was conducted with the Manager of Quality Services.

Patient 9's medical record showed the patient was admitted to the hospital on 8/6/22.

* Review of the restraint flowsheet dated 8/6/22 at 1700 hours, Patient 9 was placed in two-point soft restraints and the patient's four siderails were in the up position.

However, further review of Patient 9's medical record failed to the nursing staff obtained the physician's order for the use of restraints for Patient 9.

* Review of the restraint flowsheet dated 8/6/22 at 1800 hours, showed Patient 9 was in four-point soft restraints to all extremities and the patient's four siderails were in up position due to combative and uncooperative behavior. There was no documentation to show the nursing staff immediately informed or contacted the physician to obtain an order for the use of restraints for Patient 9.

The Manager of Quality Services confirmed the findings.

c. On 10/20/22 at 1212 hours, an interview and concurrent review of Patient 12's medical record

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| A 398 | Continued From page 70<br>was conducted with the Manager of Quality Services.<br><br>Patient 12's medical record showed the patient was admitted to the hospital on 10/8/22.<br><br>Review of the physician's order dated 10/15/22 at 0957 hours, showed to use two-point soft restraints to the patient's bilateral upper extremities due to interfering with medical device; and to monitor the use of restraint every two hours for 24 hours.<br><br>Review of the restraint flowsheet showed Patient 12 was in two-point soft restraints to bilateral upper extremities on 10/15/22 at 0842 hours. The patient was in two-point soft restraints on 10/15/22 at 1000, 1200, 1400, 1600, 1800, 2000, 2200 hours; and on 10/16/22 at 0000, 0200, 0800, and 1018 hours.<br><br>Review of the physician's order showed the RN updated the "Restraint to continue - Renewal Non-Violent (Completed)" for Patient 12 on 10/16/22 at 0843 hours. There was no documentation to show the physician signed the order for restraint use that was updated by the RN on 10/16/22.<br><br>The Manager of Quality Services confirmed the findings. | A 398 | | |
| A 410 | BLOOD TRANSFUSIONS AND IV MEDICATIONS<br>CFR(s): 482.23(c)(4)<br><br>Blood transfusions and intravenous medications must be administered in accordance with State law and approved medical staff policies and | A 410 | | |

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| A 410 | Continued From page 71<br>procedures.<br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the hospital failed to ensure the nursing staff implemented the hospital's P&P related to the blood transfusion for three of 17 sampled patients (Patients 6, 7, and 8) as evidenced by:<br><br>1. For Patient 6, the nursing staff failed to timely administer the blood products as ordered to the patient. In addition, there was no documented evidence to show the nursing staff checked the patient's information, checked the patient's vital signs, or completed the platelet transfusion record for Patient 6.<br><br>2. For Patient 7, there was no documented evidence to show the nursing staff checked the patient's vital signs at the start of the transfusion (or the baseline vital signs), at 15 minutes after the start of the transfusion, and at the completion of the transfusion. In addition, the date of the start the blood transfusion was not accurately recorded when the nursing staff administered the plasma product to Patient 7 on 10/8/22.<br><br>3. For Patient 8, the nursing staff did not ensure the physician signed the Blood Transfusion Information and Consent when administering the blood product to the patient.<br><br>These failures had the potential to put the patients at risk for negative health outcomes.<br><br>Findings:<br><br>Review of the hospital's P&P titled Blood and Blood Product: Obtaining a Specimen; Obtaining Blood from Blood Bank; Administration of Blood | A 410 | | |

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| A 410 | Continued From page 72<br>Product; Monitoring the Patient, dated 9/23/22, showed the following:<br><br>* The Obtaining Order and Consent section showed it is the physician's responsibility to secure the patients informed consent whenever it seems likely that a patient's condition will require blood transfusion.<br><br>* The Administration of Blood and Blood Components section showed the following:<br><br>- Validate that the patient has signed the Blood Transfusion Information and Consent Form and the physician signs the Paul Gann portion of this form at the beginning of the transfusion.<br><br>- Two licensed nurses, or a physician and licensed nurse must check the information printed on the Blood Bank Transfusion Record and the information printed on the blood bag identification label against the patient's wristband before beginning any transfusion,<br><br>- Record the patient's pre-transfusion vital signs in the place provided. Baseline vital signs should be taken before the initiation of the transfusion for subsequent comparison.<br><br>- To begin the transfusion, spike the unit using aseptic techniques.<br><br>- Take vital signs again and record the 15-minute vital signs on the Blood Bank Transfusion Record EMR. In case of transfusion less than 15 minutes, record only pre and post vital signs.<br><br>- Obtain and record the patient's vital signs again at the completion of the transfusion and sign the | A 410 | | |

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transfusion record in the space marked "Transfusion Completed" EMR.

1. On 10/19/22 at 1300 hours, review of Patient 6's medical record was initiated.

Patient 6's medical record showed the patient was admitted to the hospital on 9/24/22 through the ED.

Review of the Admission H&P EMR No Cosign dated 9/23/22 at 1859 hours, showed Patient 6 was instructed to go to the ED for blood transfusions. The patient had anemia and thrombocytopenia. The plan was to transfuse one unit of PRBC and one unit of platelet.

Review of the physician's orders dated 9/23/22 at 1528 hours, showed to administer one unit of PRBC STAT and one unit of platelet STAT for active bleeding.

* Review of the Transfusion Audit Report showed the PRBC was administered to Patient 6 on 9/23/22 at 2345 hours, or eight hours and 17 minutes later.

* Review of the Transfusion Audit Report showed the platelet product was dispensed for Patient 6 on 9/23/22 at 2025 hours. Further review of the Transfusion Audit Report for the platelet showed the following:

- There were no signatures by two nurses or a physician and licensed nurse to show the staff hAD checked the information as per the hospital's P&P.

- There was no documented evidence to show

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| A 410 | Continued From page 74<br>what time the platelet transfusion was started.<br><br>- There were no vital signs recorded.<br><br>- There was no documented evidence to show when the platelet transfusion was completed.<br><br>On 10/19/22 at 1500 hours, an interview and concurrent review of Patient 6's medical record was conducted with the Manager of Quality Services, the Lab Director, and the Clinical Lab Scientist. When asked if the platelet product was dispensed for Patient 6 and who picked up the platelet product. The Lab Director retrieved the information from the EMR that showed the Platelet product was picked up for Patient 6 on 9/23/22 by a "runner," and delivered to the nurse on the unit. When asked how it could be verified that the platelet product was administered to Patient 6, the Manager of Quality Services stated she would look into it and find out if it was administered to the patient. When asked if there was a reason why the blood transfusion was not administered to the patient STAT as ordered, the Manager of Quality Services could not answer.<br><br>On 10/19/22 at approximately 1600 hours, a follow-up interview was conducted with the Manager of Quality Services. The Manager of Quality Services stated the error happened on the 4 EAST, but the nurse stated the platelet product was administered to Patient 6. The Manager of Quality Services confirmed the findings.<br><br>2. On 10/20/22 at 0940 hours, an interview and concurrent review of Patient 7's medical records was conducted with the Manager of Quality Services. | A 410 | | |

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| A 410 | Continued From page 75<br>Patient 7's medical record showed the patient was admitted to the hospital on 10/6/22.<br><br>Review of the Transfusion Audit Report showed the nursing staff administered to Patient 7 the plasma product. The form showed the plasma transfusion was started on "12/31/22" at 1034 hours and stopped on "10/8/22" at 1100 hours. There was no documented evidence showing the nursing staff checked the patient's vital signs at the start of the transfusion (or the baseline vital signs), at 15 minutes after the start of the transfusion, and at the completion of the transfusion.<br><br>The Manager of Quality Services confirmed the findings.<br><br>3. On 10/20/22 at 1240 hours, an interview and concurrent review of Patient 8's medical record was conducted with the Manager of Quality Services.<br><br>Patient 8's medical record showed the patient was admitted to the hospital on 8/18/22.<br><br>Review of the physician's order dated 8/19/22 at 1203 hours, showed to transfuse one unit of platelet for Patient 8.<br><br>Review of the Progress Note EMR No Cosign SOAP dated 8/19/22 at 1202 hours, showed one unit of platelet would be given to Patient 8; the patient agreed after the discussion of risks and benefits.<br><br>Review of the Blood Transfusion Information and Consent (with Physician Verification) showed Patient 8 signed the consent on 8/19/22 at 1430 | A 410 | | |

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| A 410 | Continued From page 76<br>hours. However, the physician did not sign and date the form to verify the physician had discussed the advantages, disadvantages, risks, and benefits of the autologous blood and of directed and non-directed homologous blood from volunteers.<br><br>Review of the Transfusion Audit Report showed one unit of platelet was administered to Patient 8 on 8/19/22 at 1605 hours.<br><br>When asked if the physician should have signed the Blood Transfusion Information and Consent (with Physician Verification), the Manager of Quality Services stated, yes. The Manager of Quality Services further stated the physician mentioned in the progress note that Patient 8 agreed. When asked, the Manager of Quality Services stated the physician should have signed the Blood Transfusion Information and Consent (with Physician Verification) form. The Manager of Quality Service verified the findings. | A 410 | | |
| A 700 | PHYSICAL ENVIRONMENT<br>CFR(s): 482.41<br><br>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.<br>This CONDITION is not met as evidenced by:<br>Based on observation, interview, and record review, the hospital failed to ensure the safety of patients and staff was maintained as evidenced by:<br><br>1. Failure to maintain a safe and sanitary environment throughout the hospitals, including | A 700 | | |

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| A 700 | Continued From page 77<br>the ED, 4 EAST, ICU, DOU, MBCU, NICU, L&D, and 3 EAST units. Cross reference to A701.<br><br>2. Failure to ensure the temperature and humidity levels in the exam room of the MBCU were maintained properly. Cross reference to A726.<br><br>The cumulative effect of these failures resulted in the hospital's inability to provide quality healthcare in a safe and sanitary environment creating the increased risk of poor health outcomes to the patients. | A 700 | | |
| A 701 | MAINTENANCE OF PHYSICAL PLANT<br>CFR(s): 482.41(a)<br><br>The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.<br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the hospital failed to maintain a safe and sanitary environment throughout the hospitals, including the ED, 4 EAST, ICU, DOU, MBCU, NICU, L&D, and 3 EAST units. This failure had the potential for the patients to be at risk for harm or poor health outcomes.<br><br>Findings:<br><br>1. On 10/17/22 at 1432 hours, an observation and concurrent interview was conducted with the Quality Director and Manager of Quality Services. The glass door that led to the outdoor patio was observed ajar. The the Quality Director and Manager of Quality Services stated the door should be closed at all times. The Manager of | A 701 | | |

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| A 701 | Continued From page 78<br>Quality Services acknowledged that having the door opened was an opportunity for insects and other pests to enter and infest the facility. The Manager of Quality Services confirmed the findings and also acknowledged the hospital continued to have pest control issues.<br><br>2. On 10/17/22 at 1427 hours, observation and concurrent interview was conducted with the Quality Director and Manager of Quality Services. Multiple doors in the ICU, including the clean supply room were observed propped open. The Quality Director and Manager of Quality Services acknowledged the safety issues with having doors propped open, specifically the fire doors and the doors with badge access that should not be accessed by unauthorized staff and/or by visitors.<br><br>3. On 10/18/22 at 1435 hours, the ED was toured with the Quality Director, Manager of Quality Services, and ED Manager. The following was observed:<br><br>* In the outdoor patient waiting area:<br><br>- Two oxygen tanks were not secured on a stand.. One oxygen tank was on its side and laying on the ground.<br><br>- One patient chair with a broken seat.<br><br>- One vital signs machine base with a thick layer of dust and multiple black surgical masks on the ground.<br><br>- On the grassy area next to the security guard podium, one fire extinguisher was on the ground, not mounted and unsecured. | A 701 | | |

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| A 701 | Continued From page 79<br><br>* In the ED lobby, one sealed urine specimen container was observed on a metal tray stand, left unattended and in close proximity to the door that lead to the triaging area or a high-traffic area.<br><br>* In the Triaging area, multiple bottles of water that were labeled for patients and disposable drinking cups that were stacked up, were placed on the countertop next to multiple urine specimens.<br><br>* In the ED Pod:<br><br>- The patient restroom was cluttered with multiple patient commodes stacked up.<br><br>- One crash cart was not plugged into the emergency backup power outlet.<br><br>* In the ED staff breakroom:<br><br>- The staff shower was cluttered and not readily available or accessible for staff use.<br><br>- The kitchen countertop and floors with stains and food particles.<br><br>- Multiple ceiling tiles with stains.<br><br>* In the clean utility room:<br><br>- One ice machine was observed on the countertop next to the hand-washing sink. The drawers and shelves below the ice machine contained the patient care and medical supplies, including razors, toothbrushes, paste, peds ambu bags, briefs, and peripads. Under the ice machine and on the countertop, white | A 701 | | |

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| A 701 | Continued From page 80<br>residue/stains, spilled water, and rust were observed around the base of the ice machine. The ice machine drain line was placed in the hand-washing sink and the end of the ice machine drain line was touching the sink.<br><br>- The cabinets used for storing medical and patient care supplies with damaged laminate exposing the pressed wood.<br><br>- In the soiled utility room: there were one black wheelchair and one oxygen tank. The ED Manager stated she believed those were the patient owned. The ED Manager stated they should be labeled with the patient's name.<br><br>The Quality Director and Manager of Quality Services were informed and acknowledged the above finding.<br><br>4. On 10/18/22 at 1600 hours, a tour 4 EAST was conducted with the Quality Director. The following was observed:<br><br>* Staff breakroom kitchen sink appeared clogged. Approximately one inch of standing water was observed in the sink.<br><br>* Staff breakroom refrigerator interior with spills, stains, and food particles.<br><br>* Staff breakroom window shade with multiple stains.<br><br>* Soiled utility room with an unsanitary hand-washing sink. The hand-washing sink had dirt, grime, and rust-colored stains/residue.<br><br>* Multiple white small countertop outside of each | A 701 | | |

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| A 701 | Continued From page 81<br>patient room with tape residue, stains, and dust.<br><br>* One patient room with a broken PPE dispenser.<br><br>* In the Dialysis Treatment room, the following was observed:<br><br>- One large brown stain found underneath a storage cabinet with multiple ants were crawling on the floor and along the baseboard.<br><br>- One cabinet drawer with a rusted handle.<br><br>- Multiple metal tray stands with dust on the base and with tape or sticky residue on the trays.<br><br>- Food items observed in a storage cabinet.<br><br>- One patient bathroom that was being utilized to store and sanitize dialysis reusable supplies was not labeled or identified as not to be used by patients. In addition, the bathroom floor had multiple stains/residue observed under the hand-washing sink.<br><br>* One patient bathroom was not maintained in a sanitary manner. The shower tile had black/brown mold-like appearing spots.<br><br>* One staff chair was observed with multiple tears.<br><br>* At the nursing station, the counter tops and high touch area were damaged or broken, making them difficult to be properly sanitized.<br><br>* The hand-washing sink at the nursing station with brown/black stains/residue around the laminate countertop and backsplash. | A 701 | | |

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| A 701 | Continued From page 82<br><br>* Medication room floor had stains and dust throughout.<br><br>* In the patient pantry, the following was observed:<br><br>- The refrigerator with stains and residue on the inside and on the outside.<br><br>- The bottom cabinet with disinfecting products stored next to patient drinking supplies.<br><br>- Stains and debris under the sink.<br><br>The Quality Director confirmed the above findings.<br><br>5. On 10/19/22 at 1015 hours, a tour of the trash and linen storage areas was conducted with the EVS Director, Quality Director, and Manager of Quality Services. One cart was observed with multiple bags that were opened and not tied closed. The bags contained what appeared to be wet rags and black kitchen aprons. The cart was labeled that the contents were not trash. When asked why the bags were not closed, the EVS Director did not provide a response.<br><br>6. On 10/19/22 at 1035 hours, a tour of the food delivery entrance walkway was conducted with the Quality Director and Manager of Quality Services. The following was observed:<br><br>* One trash container with wheels that contained bags with trash, was missing the lid. While conducting observations of the multiple kitchen equipment lined up outside the food delivery entrance, Food Service Worker 1 was observed | A 701 | | |

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| A 701 | Continued From page 83<br>exiting the kitchen, putting a trash bag in the trash container, and then walking away. When interviewed, Food Service Worker 1 acknowledged the trash container did not have a lid, and stated the trash container would be emptied later.<br><br>* The hallway of the kitchen and morgue area was cluttered by a morgue gurney. Within a few feet of the morgue gurney, there were multiple meal tray delivery carts that were lined up in the hallway.<br><br>The Quality Director and Manager of Quality Services confirmed the findings.<br><br>7.a. On 10/18/22 at 1405 and 1505 hours, a tour of the ICU was conducted with the Manager of Quality Services. The following was identified:<br><br>* Two showers rooms in Rooms A and B were observed to be dirty with old mold on the shower floors. The shower room in Room B had a chair and dirty towels.<br><br>* The temperature level of the freezer that used to store the patients' food, was 20 degrees Fahrenheit. The Manager of Quality Services requested to have a work order after bringing it to her attention.<br><br>b. On 10/20/22 at 0902 hours, a tour of ICU was conducted with the Quality Director, Manager of Quality Services, and the Director of ICU and DOU. The following was identified:<br><br>* The blanket warmer was observed with the temperature level of 142 degrees Fahrenheit, which exceeded the recommended temperature | A 701 | | |

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| A 701 | Continued From page 84<br>of 120 degrees Fahrenheit.<br><br>Review of the Blanket Warmer Temperature Check log showed the temperature levels had not been completed for five shifts in October 2022 and for at least 20 shifts in September 2022.<br><br>* One bronschoscopy supplies box or "Bronch Tackle Box" was observed with multiple expired supplies.<br><br>Review of the Bronch Box Check List showed at least 10 supplies, including sterile gloves, filtered needles, vacutainer, and forceps had expired. The box was on a cart in the hallway and readily available and accessible for use.<br><br>* In the ICU pod with multiple patients, the patient's restroom had one large red biohazard bag that was opened and tied to the toilet handrail.<br><br>* In the Soiled utility room: the following was observed:<br><br>- There was no trash container.<br><br>- Two large trash bags with foul odor were stacked on top of a bear hugger.<br><br>The Director of ICU and DOU confirmed the trash bags should be in a trash container; there was no trash container in the room. The Director of ICU and DOU stated the "old bear hugger" was not functional and it should have been picked up. The Director of ICU and DOU acknowledged the bear hugger was not tagged or identified as being broken or not functional. | A 701 | | |

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| A 701 | Continued From page 85<br>- One red sharps container was not secured on the wall, was sitting on the counter, and was over the FULL line.<br><br>* In the POD (Beds 18 through 22), the following was observed:<br><br>- In the patient's restroom, two patient commodes and one urine collection container were on the floor. One urinal was hanging on one of the commodes. The Director of ICU and DOU confirmed the urinal and the urine collection container were not labeled. The Director of ICU and DOU also confirmed one of the commodes was "dirty."<br><br>- The hand-washing station in the main nursing station was observed with black/brown residue/spots behind the sink and behind/around the hand soap dispenser.<br><br>- The employee lounge was not maintained in a sanitary manner. The trash, dust, and food debris were on the floor. The refrigerator with stains/spills on the inside and the outside of the refrigerator.<br><br>The Quality Director and Manager of Quality Services confirmed the findings.<br><br>8.a. On 10/18/22 at 1505 hours, a tour of the DOU was conducted with the Manager of Quality Services. A fly was observed flying out from the staff's lounge onto the unit when the door was open. The Manager of Quality Services confirmed the findings.<br><br>b. On 10/20/22 at 1027 hours, a tour of DOU was conducted with the Quality Director and Manager | A 701 | | |

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| A 701 | Continued From page 86<br>of Quality Services. The following was observed:<br><br>* The drinking fountain in the hallway that was across Room 157, was currently not in use. The drinking fountain had a thick layer of dust on the clear plastic that was wrapped around the drinking fountain with yellow tape.<br><br>* The employee lounge was not maintained in a sanitary manner. The trash, dust, and food debris were on the floor, specifically underneath the staff lockers. A large piece of cardboard was placed under the coffee machine.<br><br>The Quality Director and Manager of Quality Services confirmed the findings.<br><br>9. On 10/20/22 at 1049 hours, a tour of the MBCU was conducted with the Quality Director and Manager of Quality Services. The following was identified:<br><br>* In the patient pantry, the ice/water machine was tested and was functional; however, the freezer compartment of the patient refrigerator had two bath basins full of ice. The OB Nurse Manager stated the ice in the freezer was used for the patients when the ice machine was broken.<br><br>* In the dirty utility room, the following was observed:<br><br>- One IV pump chamber with an expired PM sticker. The Biomedical Engineering sticker showed the Next PM due was 8/2022.<br><br>- One large blue plastic bag with what appeared to be unlaundered towels, was stored in the bottom cabinet. Under the blue bag, the shelf | A 701 | | |

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| A 701 | Continued From page 87<br>had extensive damaged laminate exposing the pressed wood.<br><br>* In the physician's sleep room, the following was observed:<br><br>- When the window blind was pulled back, large amount of cobwebs was observed<br><br>- On the window frame, a small hole that was large enough for insects to get in through.<br><br>- In the shower, multiple white/gray stains/spots were on the tile, drain, and handlebar.<br><br>* In the clean OB storage room, the following was observed:<br><br>- One used phlebotomy cart that was damaged and was reinforced with a cardboard-like material and with tape and sticky residue throughout, which would not allow for proper disinfection. A large sharp waste container was attached to the cart and filled almost to the FILL line.<br><br>- At least 10 newborn bassinets with mattresses were observed in storage. Multiple tears and cracks on each mattress were identified.<br><br>- One bassinet had dust and black debris on the inside.<br><br>- One patient room PPE holder was on the ground.<br><br>* In the exam room where the circumcision procedures were performed, the following was observed: | A 701 | | |

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|---|---|---|---|
| | 050570 | A. BUILDING _____ B. WING _____ | C 10/21/2022 |

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

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| A 701 | Continued From page 88<br>- The exam room was cluttered with multiple patient care equipment on wheels.<br><br>- A thick layer of dust was observed on the multiple patient care equipment including vital signs machines.<br><br>- Debris and dust on the floor.<br><br>* In the employee lounge, the following was observed:<br><br>- The space was not maintained in an organized and sanitary manner. Spills, debris, and dust were throughout the employee lounge. The refrigerator had spills and food particles. Multiple black chairs with porous fabric had multiple tears and white spots/stains.<br><br>The Quality Director and Manager of Quality Services confirmed the findings.<br><br>10. On 10/20/21 at 1201 hours, a tour of the NICU was conducted with the Quality Director and Director of NICU. The following was observed:<br><br>* The NICU transport incubator was not plugged in to the emergency backup power outlet.<br><br>11. On 10/20/21 at 1211 hours, a tour of the L&D unit was conducted with the Quality Director and the L&D Manage. The following was identified:<br><br>* In the employee lounge, the following was observed:<br><br>- The space was not maintained in an organized and sanitary manner. Spills, debris, sticky | A 701 | | |

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| A 701 | Continued From page 89<br>residue, and dust were observed throughout the employee lounge. The refrigerator had spills and food particles.<br><br>- The sink with dirty dishes.<br><br>- The drawers, cabinets, and shelves with extensive damaged laminate, exposing the pressed wood.<br><br>- Large food particles and dust/debris behind the water dispenser.<br><br>- The kitchen table with extensive damaged laminate exposing the pressed wood.<br><br>- Multiple ceiling tiles with stains and water damage.<br><br>- The scrub cart cover was stained and in disrepair.<br><br>* At the pneumatic tube system by the nursing station, the blue disposable bed pads and bed linen were observed. When the blue disposable bed pads and bed linen were removed, the thick rust-colored residue in the inner corners was observed.<br><br>The above identified unsanitary and unsafe hospital environment issues including the ED, 4 EAST, ICU, DOU, NICU, MBCU, and L&D were all acknowledged by the Quality Director and Manager of Quality Services on 10/20/22 at the end of the tour.<br><br>12. On 10/19/22 at 1040 hours, a tour of the hospital's grounds was conducted with the Manager of Quality Services. The following was | A 701 | | |

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| A 701 | Continued From page 90<br>identified:<br><br>* The ceilings in the hallway near the kitchen and the morgue area was observed with water damage.<br><br>* Mold and dust were observed behind the wall mirror.<br><br>The Manager of Quality Services confirmed the findings.<br><br>13. On 10/18/22 at 1600 hours, a tour of the 3 EAST was conducted with Nurse Manager 1 and the Manager of Quality Services. In the pantry room, the right bottom cabinet doors were taped with the red tape all around. When asked why the red tape was there, Nurse Manager 1 stated it was broken. There was label or tag to indicate the doors were broken. | A 701 | | |
| A 726 | VENTILATION, LIGHT, TEMPERATURE CONTROLS<br>CFR(s): 482.41(d)(4)<br><br>There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.<br>This STANDARD is not met as evidenced by:<br>Based on observation, interview, and record review, the hospital failed to ensure the temperature and humidity levels in the exam room of the MBCU were maintained properly to provide a safe hospital environment for the patients receiving care in this exam room. This failure had the potential to result in poor health outcomes to the patients.<br><br>Findings: | A 726 | | |

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| A 726 | Continued From page 91<br><br>On 10/20/22 at 1131 hours, a tour of the MBCU was conducted with the Quality Director, Manager of Quality Services, and L&D Manager. When asked, the L&D Manager stated the exam room was where circumcision procedures were performed; and where medical supplies that required temperature and humidity control, were stored.<br><br>During the tour of the exam room, the following was observed:<br><br>* On the wall, a wall mounted with the digital "Hygro-Thermometer." The label on the thermometer showed "EXTECH Calibrated" and the due date was 8/24/22.<br><br>* Review of the Temperature and Humidity Readings logs for the exam room showed:<br><br>- The temperature range would be 68-75 degrees Fahrenheit.<br>- The humidity range would be 30%-60%<br><br>* Review of the temperature and humidity logs for May, June, July, August, September, and October 2022 showed the following:<br><br>- On 5/21/22, the temperature level was 75.4 degrees Fahrenheit. The log did not show documentation of action taken.<br><br>- On 6/12/22, the temperature level was 75.7 degrees Fahrenheit. The log did not show documentation of action taken.<br><br>- On 6/19 and 6/20/22, the temperature level was 75.6 degrees Fahrenheit. The log did not show | A 726 | | |

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| A 726 | Continued From page 92<br>documentation of action taken.<br><br>- On 7/15, 7/17, and 7/18/22, the temperature levels were 76.3, 78.6, and 77. 2 degrees Fahrenheit, respectively. The temperature and humidity log showed "Engr (sic) aware - aircon- (sic) ditioning was down" on 7/17/22; "Aircondition down (repair in progress)" and "No thermostat in room" and "Called Engineering but they have no idea also" on 7/18/22.<br><br>- From 7/19 through 7/23/22, from 7/25 through 7/27/22, and from 7/29 and 7/30/22, the log showed there was no thermostat.<br><br>- On 7/24, and 7/28/22, there was no entry on the log.<br><br>- On 8/1/22, from 8/3 through 8/14/22, and from 8/16 though 8/31/22, the log showed "No thermostat" and no temperature or humidity recordings.<br><br>- On 8/2 and 8/15/22, there was no documentation or entry to the log.<br><br>- On 8/19/22, the log showed that "engineering notified."<br><br>- From 9/1 through 9/30/22, there were no temperature or humidity recordings. The log showed "No Thermostat." The log did not show documentation of action taken.<br><br>- For 10/1/22 through 10/10/22, there were no temperature or humidity recordings. The log showed "No Thermostat." The log did not show documentation that any action was taken. | A 726 | | |

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| A 726 | Continued From page 93<br>The findings were shared with the Manager of Quality Services. | A 726 | | |

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**CMS Certification Number (CCN): 050570**

The plan of correction is prepared in compliance with federal regulations and is intended as Fountain Valley Regional Hospital and Medical Center's evidence 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.

**Plan of Correction:**

**Tag A 043**

**Response:**
The Governing Board has received a summary of findings from the report written by The Centers for Medicare and Medicaid Services (CMS) dated 11/30/2022. The Chief Executive Officer convened a meeting of the Board on 12/06/2022, to review the report findings. The report including the plan of correction will be presented to the entire Governing Board on 01/26/2023. The Governing Board has taken the allegations of deficiency in the report seriously and continues to assume full responsibility for determining, implementing, and monitoring staffing compliance, safety of the hospital, and cleanliness of the hospital.

The Governing Board continues to maintain an effective, ongoing, hospital-wide, data driven quality assessment and performance improvement program. The scope of the hospital's Quality Assessment Performance Improvement program reflects the scope of the hospital departments and services, including Nursing Services. The hospital's Quality Assessment Performance Improvement program uses indicators related to outcomes, to identify and track quality of care issues, to foster patient safety and to prevent medical errors and involves all hospital departments and services, as indicated.

The Governing Board continues to hold the medical staff and nursing services accountable for the quality of care and services provided to patients through the routine reporting, analysis, and action of the hospital's performance improvement activities.

In addition, the Governing Board, the Chief Executive Officer, and the Chief Nursing Officer work collaboratively together to ensure the hospital complies with required staffing ratios. There is a defined process in place to ensure oversight at the Governing Board level.

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**Policy and Procedure:**
The Chief Executive Officer, the Chief Nursing Officer, the Chief Operating Officer and hospital leadership have reviewed and/or revised the applicable policies related to this plan of corrections. Completed on 12/12/2022.

**Training:**
The Governing Board requested that the Chief Executive Officer and the Chief Nursing Officer require that education be provided to the appropriate staff on the policies and procedures that they reviewed/ and or revised, with the expectation that staff would follow the policies and procedures in the provision of care and services. In addition, the Chief Executive Officer and Chief Nursing Officer reviewed the expectations of meeting minute documentation with the administrative team responsible for Governing Board minutes.

**Monitoring:**
To closely oversee the sustained effectiveness of the changes and training accomplished, the Director of Clinical Quality Improvement implemented monitoring to take place surrounding each of the improvement efforts. This monitoring will be reported to Executive Nurse Council Executive Nurse Council , Quality Patient Care Committee, Medical Executive Committee, and the Governing Board at their regularly scheduled meetings until compliance has been achieved for three months. The indicators will be monitored as described throughout the body of this plan of correction and at least quarterly to confirm sustainability of the corrective actions.

The Chief Executive Officer or designee will monitor the Governing Board minutes monthly upon each meeting of the Governing Board to confirm completeness and accuracy of the minutes produced by the administrative assistant or designee.

**Responsible Parties:**
The Director of Clinical Quality Improvement in conjunction with the Chief Executive Officer, Chief Nursing Officer, the Medical Executive Committee, and the Governing Board will be responsible to ensure that all actions identified in this plan of correction are implemented and monitored.

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**Tag A 049**

**1. Failed to ensure the medical staff provided quality of care - Did not accurately complete the medical records**

**Policy and Procedure:**
The Director of Clinical Quality Improvement, the Chief of Staff and the Chief Nursing Officer reviewed hospital policy titled Wound and Skin Care Guidelines Management, and Documentation (FVR NUR 113.0), Restraint and Seclusion (CLN.02.06), Documentation: Transfusion Information and Consent (FVR BB 115.0), and Medical Bylaws confirmed no revisions to the policies were required.
Completion Date: 12/5/2022

**Corrective Action/Training:**
Upon notification of the survey findings, the Chief of Staff and the Clinical Quality Director created a memo with survey findings to share with medical staff on 12/6/2022 with a focus on the following:

- Required elements of History and Physical (H&P) and timely completion
- Hospital Acquired Pressure Injury progress note documentation
- Restraint orders, and documentation of continued need for restraints
- Blood Transfusion Consent requirements, including date and time

In addition, all CMS Validation Survey findings will be discussed at the next MEC meeting-on 01/19/2023.
Completion Date: 1/12/2023

**Monitoring:**
The Director of Clinical Quality Improvement or designee will audit the following Medical Staff documentation:

- H&P for completion to ensure all elements as specified in the Medical Bylaws are present as well as completion within 24 hours.
- Evidence of documentation in the physician's progress note of any Hospital Acquired Pressure Injuries.
- Documentation for the continued need of restraints and restraint renewal orders.
- Blood transfusions consents dated, timed and signed by the physician.

The Director of Clinical Quality Improvement or designee will conduct 30 chart audits monthly to confirm complete medical records per policy. Monitoring will occur until 3 consecutive months at 100% compliance is achieved. After 3 consecutive months of 100% compliance, audits will be performed at least quarterly to confirm sustainability of corrective actions. Data will be tracked and trended for process improvement initiatives and reported up to Quality Patient Care Committee, Medical Executive Committee and Governing Board at their regularly scheduled meetings for review and action as required.
Start Date: 1/12/2023 and ongoing.

**Disciplinary Action:**
Medical Staff members demonstrating non-compliance with corrective action will be referred for peer review in accordance with Medical Staff bylaws, as appropriate.

**Responsible Person(s):**
Chief of Staff, Director of Clinical Quality Improvement

**Tag A 263**

**Policy and Procedure:**
The Chief Executive Officer, the Chief Nursing Officer and Director of Clinical Quality Improvement have revised the Performance Improvement Plan (FVR ADM 45.0) to include Environment of Care and staffing effectiveness as a performance measure.
Completed on 12/16/2022

**Training/Actions Taken:**
On 12/6/2022, a special meeting of the Governing Board was convened and a report was given on the current status of staffing effectiveness and Environment of Care at the facility.

Compliance with staffing surge plan will be analyzed and presented by the Chief Nursing Officer to the Executive Nurse Council, , Quality Patient Care Committee, Medical Executive Committeee, and Governing Board as a regularly scheduled agenda item. The Governing Board discussion, recommendations and actions taken will be documented in the minutes to protect and promote patient safety, patient rights and quality of patient care.

In addition, data regarding Environment of Care compliance will be analyzed and presented by the Chief Operating Officer to the Environment of Care Committee, Quality Patient Care Committee, Medical Executive Committee, and Governing Board as a regularly scheduled agenda item. The Governing Board discussion, recommendations and actions taken will be documented in the minutes to promote a safe and sanitary environment of care.

**Monitoring:**
To closely oversee the sustained effectiveness of the changes and training accomplished, the Director of Clinical Quality Improvement implemented monitoring to take place surrounding each of the improvement efforts. This monitoring will be reported to Quality Patient Care Committee, Medical Executive Committee, and the Governing Board at their regularly scheduled meetings. These indicators will be monitored at least quarterly to confirm sustainability of the corrective actions. The indicators to be monitored are described throughout the body of this plan of correction.

The Governing Board continues to hold the medical staff and nursing services accountable for the quality of care and services provided to patients through the routine reporting, analysis, and action of the hospital's performance improvement activities.

In addition, the Governing Board, the Chief Executive Officer, and the Chief Nursing Officer work collaboratively together to ensure the hospital complies with required staffing ratios. There is a defined process in place to ensure oversight at the Governing Board level.

The Chief Executive Officer or designee will monitor the Governing Board minutes monthly upon each meeting of the Governing Board to confirm completeness and accuracy of the minutes.

**Responsible Parties:**
The Director of Clinical Quality Improvement in conjunction with the Chief Executive Officer, Chief Nursing Officer, the Medical Executive Committee, and the Governing Board will be responsible to ensure that all actions identified in this plan of correction are implemented and monitored.

**Tag A 283**

**Policy and Procedure:**
The Chief Executive Officer, the Chief Nursing Officer, and Director of Clinical Quality Improvement have revised the Performance Improvement Plan (FVR ADM 45.0) to include Environment of Care and staffing effectiveness as a performance measure.
Completed on 12/16/2022

**Training/Actions Taken:**
On 12/6/2022, a special meeting of the Governing Board was convened and a report was given on the current status of staffing effectiveness and Environment of Care at the facility.

Compliance with staffing surge plan will be analyzed and presented by the Chief Nursing Officer to the Executive Nurse Council Executive Nurse Council , Quality Patient Care Committee, Medical Executive Committee, and Governing Board as a regularly scheduled agenda item. The Governing Board discussion, recommendations and actions taken will be documented in the minutes to protect and promote patient safety, patient rights and quality of patient care.

In addition, data regarding Environment of Care compliance will be analyzed and presented by the Chief Operating Officer to the Environment of Care Committee, Quality Patient Care Committee, Medical Executive Committee, and Governing Board as a regularly scheduled agenda item. The Governing Board discussion, recommendations and actions taken will be documented in the minutes to promote a safe and sanitary environment of care.

**Monitoring:**
To closely oversee the sustained effectiveness of the changes and training accomplished, the Director of Clinical Quality Improvement implemented monitoring to take place surrounding each of the improvement efforts. This monitoring will be reported to Quality Patient Care Committee, Medical Executive Committee, and the Governing Board at their regularly scheduled meetings. These indicators will be monitored at least quarterly to confirm sustainability of the corrective actions. The indicators to be monitored are described throughout the body of this plan of correction.

The Governing Board continues to hold the medical staff and nursing services accountable for the quality of care and services provided to patients through the routine reporting, analysis, and action of the hospital's performance improvement activities.

In addition, the Governing Board, the Chief Executive Officer, and the Chief Nursing Officer work collaboratively together to ensure the hospital complies with required staffing ratios. There is a defined process in place to ensure oversight at the Governing Board level.

The Chief Executive Officer or designee will monitor the Governing Board minutes monthly upon each meeting of the Governing Board to confirm completeness and accuracy of the minutes.

**Responsible Parties:**
The Director of Clinical Quality Improvement in conjunction with the Chief Executive Officer, Chief Nursing Officer, the Medical Executive Committee, and the Governing Board will be responsible to ensure that all actions identified in this plan of correction are implemented and monitored.

**Tag A 315**

**Failed to ensure GB meeting minutes included documentation related to QAPI and analysis regarding staffing and EOC**

**Policy and Procedure:**
The Chief Executive Officer, Chief Nursing Officer, Director of Patient Safety, and Director of Clinical Quality Improvement reviewed the hospital Governing Board bylaws and confirmed no changes were required.
Completion Date: 12/12/22

**Corrective Action/Training:**
The Chief Executive Officer and Chief Nursing Officer reviewed the expectations of meeting minute documentation with the administration team for Governing Board minutes. The education focused on ensuring each Governing Board meeting's agenda, discussion, conclusions, recommendations, and actions/follow-up are captured appropriately within the minutes and provide a thorough and accurate reflection of the Governing Board meetings. Education was completed on 12/05/2022.
Completion Date: 12/05/2022

**Monitoring:**
The Chief Executive Officer or designee will monitor the Governing Board minutes monthly upon each meeting of the Governing Board to confirm completeness and accuracy of the minutes produced by the administrative assistant or designee. Monitoring will occur routinely on an ongoing basis as part of the executive team's roles and responsibilities.
Start Date: 12/06/2022 and ongoing.

**Responsible Person(s):**
Chief Executive Officer

**Tag A 385**

1. **Failure to ensure sufficient staffing in multiple nursing units**
2. **Failure to ensure the RN supervision and evaluation of the nursing care provided**
3. **Failure to ensure the nursing staff developed individualized nursing care plan**
4. **Failure to ensure the hospital's P&P for patient care was implemented**
5. **Failure to ensure the blood transfusion was administered to the patients as per the hospital's P&P and the physician's ordered**

**Policy and Procedure:**

The Chief Nursing Officer, and the Directors of Clinical Quality Improvement reviewed the following policies and procedures:

- Patient Classification System (Optilink PCSS) (FVR NUR 66.0)
- Nurse Staffing Plan (FVR 88.0)
- Capacity Management Plan (FVR ADM 5.0)
- Interdisciplinary Plan of Care (FVR NUR 70.0)
- Constant Observer (FVR NUR 5.0)
- Telemetry and Remote Telemetry Monitoring (FVR NUR 88.0)
- Blood & Blood Product: Obtaining a Specimen; Obtaining Blood from Blood Bank; Administration of Blood Product; Monitoring the Patient Emergency Codes (FVR NUR 15.0)
- Clinical Guidelines Venous Access Device Prevention Insertion and Maintenance (FVR NUR 2.0)
- Wound and Skin Care Guidelines, Management and Documentation (FVR NUR 113.0)

Completion Date: 12/12/2022

**Corrective Action/Training:**

The Chief Nursing Officer reviewed the corrective actions, training, and monitoring plans outlined for each of the 5 findings referenced in Tag A385 and has summarized them as noted below. The Chief Nursing Officer has reviewed this information at the Nursing Leadership meeting with all the Nursing Directors on 12/08/2022.

- The Director of the Departments re-educated the House Supervisors, Staffing Coordinators and Staffing Manager on the Staffing Compliance log with the goal of 100% staff completion by 12/16/2022. Any employee who was unable to be re-educated due to leave of absence or absenteeism will be re-educated upon return to work and prior to their first shift in assignment.
  Completion Date: 12/16/2022

- Mandatory online learning modules with attestations, deployed 12/12/22, with evidence of 100% compliance by 01/12/22. Any employee who was unable to be re-educated due to leave of absence or absenteeism will be re-educated upon return to work and prior to their first shift in assignment.
  Completion Date: 01/12//2022

**Monitoring:**

The Clinical Directors or designees complete staffing forecasting based on the volume and acuity twice daily. Any areas of concern/shortages are immediately reported up to Clinical Directors for review and action(s) as required and described above.

The Clinical Directors or their designee monitor nurse patient ratio every shift as an ongoing measure to ensure ratio follows Title 22 California Code of Regulations with 100% compliance. However, if unable, all efforts/attempts to maintain ratio will be documented and reported to the CNO/AOC. The results of the audits will be reported to Executive Nursing Council, Quality Patient Care Committee, Medical Executive Committee, and the Governing Board at their regularly scheduled meetings for review and action(s) as required.
Start Date: 12/12/2022 and ongoing.

The Nursing Directors or designee conduct random medical record audits monthly to confirm compliance with the restraint, wound and skin care guidelines and blood transfusion policy; use of Constant

Observers including compliance with order and flowsheet completion, as defined by policy; implementation of care plans relevant to the patient diagnosis and changes in the clinical condition; documentation of crash cart logs as required by policy; and random audits IV tubing to ensure labeling with expiration date present.

The Director of Clinical Quality Improvement or Designee will track and trend the above data for process improvement initiatives and report the information to Executive Nurse Council, Quality Patient Care Committee, Medical Executive Committee and Governing Board at their regularly scheduled meetings for review and action as required
Start Date: 12/12/2022 and ongoing.

**Disciplinary Action:**
Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.

**Responsible Person(s):**
Chief Nursing Officer

**Tag A 392**

**Policy and Procedure:**
Chief Nursing Officer, Director of Patient Safety, and Director of Clinical Quality Improvement, reviewed the following policies:

- Patient Classification System (Optilink PCSS) (FVR NUR 66.0) added additional language to reflect delegation of responsibilities when charge nurse with patients.
- Nurse Staffing Plan (FVR 88.0), updated to reflect current practice and operations including removal of Travelers and added Contract Staff language.
- Capacity Management Plan (FVR NUR 5.0), updated to reflect current practice and operations related to delegation of Charge Nurse Responsibilities.

Completion Date: 12/12/2022

**1. Failure to maintain the nurse-to-patient ratios**

**Corrective Action/Training:**
Immediate actions initiated during the on-site survey investigation on 10/21/2022, included reviewing current efforts in place to maintain nursing ratios, documentation of efforts, and escalation of concerns. Daily review of staffing needs and additional resources requested as identified.

The Chief Nursing Officer revised the Staffing Compliance log on 12/5/2022 that incorporated the actions taken to staff according to ratio and shared with the Nursing Leaders on 12/8/2022.

The Chief Nursing Officer and Director of Clinical Quality Improvement re-educated the House Supervisors, Staffing Coordinators and Staffing Manager on the Staffing Compliance log with the goal of 100% staff completion by 12/16/2022. Any employee who was unable to be re-educated due to leave of absence or absenteeism will be re-educated upon return to work and prior to their first shift in assignment.

Completion Date: 12/16/2022

**Monitoring:**
The Clinical Directors or designees complete staffing forecasting based on the volume and acuity twice daily. Any areas of concern/shortages are immediately reported up to Clinical Leaders or designee for review and action(s) as required and described above.

The Clinical Directors or their designee will monitor nurse patient ratio every shift as an ongoing measure to ensure ratio follows Title 22 California Code of Regulations with 100% compliance. However, if unable, all efforts/attempts to maintain ratio will be documented and reported to the CNO/AOC. The results of the audits will be reported to Executive Nursing Council, Quality Patient Care Committee, Medical Executive Committee, and the Governing Board at their regularly scheduled meetings for review and action(s) as required.
Start Date: 12/12/2022 and ongoing.

**Disciplinary Action:**
Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.

**Responsible Person(s):**
Chief Nursing Officer

**2. Failure to ensure the charge nurse was assigned for the inpatient units as per the hospital's P&P.**
**3. Failure to implement and document the nurse staffing capacity management interventions as per the hospital's P&P**
**4. Failure to implement the corrective plan to ensure the nurse-to-patient ratio was maintained.**

**Corrective Action/Training:**
The Director of Clinical Quality Improvement and Chief Nursing Officer revised the staffing compliance log on 12/05/2022 to include measures taken per the Capacity Management Plan. Re-education and attestation with the staffing coordinators conducted by Chief Nursing Officer and Director of Clinical Quality Improvement beginning on 12/08/2022 with the goal of 100% staff completion by 12/16/2022. Any employee who was unable to be re-educated due to leave of absence or absenteeism will be re-educated upon return to work and prior to their first shift in assignment.
Completion Date: 12/16/2022

**Monitoring:**
The Chief Nursing Officer or designee monitors nurse patient ratio documentation daily and efforts implemented to maintain nurse ratios to ensure compliance with documentation requirements according to corrective action plan with 100% compliance with documentation. The results of the audits will be reported to Executive Nursing Committee, Quality Patient Care Committee, Medical Executive Committee, and the Governing Board during their regularly scheduled meetings for review and action as required.

**Disciplinary Action:**

Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.

**Responsible Person(s):**
Chief Nursing Officer

**Tag A 395**

1. **Failure to ensure the heart rhythm/rate and audible alarms were verified every 4 hours for patients who were on telemetry monitoring**

**Policy and Procedure:**
The Chief Nursing Officer, and the Directors of Patient Safety, Director of Clinical Quality Improvement, reviewed the Telemetry and Remote Telemetry Monitoring (FVR NUR 88.0.0). No revisions were required.
Completion Date: 12/05/2022

**Corrective Action/Training:**
Upon notification of the survey finding, the Directors of Nursing and Clinical Education created education on the Telemetry and Remote Telemetry Monitoring policy requirements. The monitor tech re-education focused on the completeness of the telemetry log which included the verification of the cardiac rate/rhythm and alarms as well as the signed hand off communication per policy. The RN re-education focused on verifying the rhythm for each assigned patient every 4 hours and initial the central monitor telemetry log. All re-education content referenced above was provided to the Registered Nurses and Monitor techs in the Step-Down Unit, and Telemetry departments. The re-education was initiated via assigned mandatory online learning modules with attestations, deployed 12/12/2022 with evidence of 100% compliance by 01/12/2023. Any employee who was unable to be re-educated due to leave of absence or absenteeism will be re-educated upon return to work and prior to their first shift in assignment
Completion Date: 01/12/2023

**Monitoring:**
The Clinical Directors or designee will conduct a check of the telemetry log daily to confirm complete documentation of the telemetry log for signatures per policy. Monitoring will occur until 3 consecutive months with 90% compliance. After 3 consecutive months at 90% compliance, audits will be done at least quarterly to confirm sustainability of action plan. Data will be tracked and trended for process improvement initiatives and reported up to Executive Nurse Council, Quality Patient Care Committee, Medical Executive Committee and Governing Board at their regularly scheduled meetings for review and action as required
Start Date: 01/12/2023 and ongoing.

**Disciplinary Action:**
Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.

**Responsible Person(s):**
Chief Nursing Officer

**2. Failure to ensure the nursing staff completed the Constant Observer Flow Sheet form and obtain the order for the level of constant observation**

**Policy and Procedure:**
The Chief Nursing Officer, and the Director of Patient Safety, Director of Clinical Quality Improvement, reviewed the Constant Observer Usage, Assessment, Implementation and Discontinuation (FVR NUR 5.0). No revisions were required.
Completion Date: 12/05/2022

**Corrective Action/Training:**
Upon notification of the survey finding, the Directors of Nursing and Clinical Education created education on the Constant Observer Assessment, Implementation, and Discontinuation policy requirements. The re-education focused on the registered nurses' oversight of the constant observer, Constant Observer order requirements, and completeness of constant observation flowsheet per policy. All re-education content referenced above was provided to all Registered Nurses. The re-education was initiated via assigned mandatory online learning modules with attestations, deployed 12/12/2022 with evidence of 100% compliance by 01/12/2023. Any employee who was unable to be re-educated due to leave of absence or absenteeism will be re-educated upon return to work and prior to their first shift in assignment
Completion Date: 01/12/2023

**Monitoring:**
The Nursing Director of 4 East or designee will conduct random medical record audits (Total $n$=10 or 100% if fewer than 10) monthly to confirm complete documentation of the constant observer flowsheet including RN and constant observer orders per policy. Monitoring will occur until for 3 consecutive months with at 100% compliance. After 3 consecutive months at 100% compliance, audits will be done at least quarterly to confirm sustainability of action plan.. Data will be tracked and trended for process improvement initiatives and reported up to Executive Nurse Council, Quality Patient Care Committee, Medical Executive Committee and Governing Board at their regularly scheduled meetings for review and action as required
Start Date: 01/12/2023

**Disciplinary Action:**
Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.

**Responsible Person(s):**
Chief Nursing Officer

**Tag A 396**

**1.Failed to develop and maintain the care plan to address the patient's care needs**
**Policy and Procedure:**

The Chief Nursing Officer, and the Director of Clinical Quality Improvement, reviewed hospital policy titled Interdisciplinary Plan of Care (FVR NUR 70.0) and confirmed no revisions to the policy were required.
Completion Date: 12/5/2022

**Corrective Action/Training:**
Upon notification of the survey finding, the Directors of Nursing and Clinical Education created education on the Interdisciplinary Plan of Care policy requirements with a focus on initiating care plans relevant to patient diagnosis and changes in clinical condition as well as the policy requirements regarding timeliness and frequency of documentation. All Registered Nurses were re-educated via assigned mandatory online learning modules with attestations, deployed 12/12/22 with evidence of 100% compliance by 01/12/2023. Any employee who was unable to be re-educated due to leave of absence or absenteeism will be re-educated upon return to work and prior to their first shift in assignment
Completion Date: 01/12/2023

**Monitoring:**
The Director of Clinical Quality Improvement or designee will conduct 30 chart audits monthly to confirm implementation of the Interdisciplinary Plan of Care policy is performed per policy. Monitoring will occur until 3 consecutive months at 100% compliance is achieved. After 3 consecutive months at 100% compliance, the auditing will continue at least quarterly to confirm sustainability of corrective actions. Data will be tracked and trended for process improvement initiatives and reported up to the Executive Nurse Council , Quality Patient Care Committee, Medical Executive Committee and Governing Board at their regularly scheduled meetings for review and action as required
Start Date: 01/12/2023 and ongoing.

**Disciplinary Action:**
Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.

**Responsible Person(s):**
Chief Nursing Officer

**Tag A 398**

**1. Failure to ensure the crash carts were checked daily as per the hospital's P&P.**

**Policy and Procedure:**
The Chief Nursing Officer and Director of Clinical Quality Improvement reviewed hospital policy titled Emergency Codes-Environment of Care and Medical (FVR ADM 120.0).
Completion Date: 12/6/2022

**Corrective Action/Training:**
Upon notification of the survey finding, Clinical Education created education on the Crash Cart Checks policy requirements. The re-education focused on the requirements for daily crash cart checks and log documentation. All clinical staff hospital wide were educated via assigned mandatory online learning modules with attestations, deployed 12/12/22, with evidence of 100% compliance by 01/12/22. Any

employee who was unable to be re-educated due to leave of absence or absenteeism will be re-educated upon return to work and prior to their first shift in assignment.
Completion Date: 01/12/2023

**Monitoring:**
Department Directors where crash carts are stored or designee will conduct daily audits on all crash carts to confirm complete log documentation per policy. Monitoring will occur until 3 consecutive months at 100% compliance is achieved. After 3 consecutive months at 100% compliance, auditing will continue at least quarterly to confirm sustainability of corrective action. Data will be tracked and trended for process improvement initiatives and reported up to the Executive Nurse Council, Quality Patient Care Committee, Medical Executive Committee and Governing Board at their regularly scheduled meetings for review and action as required
Start Date: 01/12/2023 and ongoing.

**Disciplinary Action:**
Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.

**Responsible Person(s):**
Chief Nursing Officer

**2. Failure to ensure the nursing staff implemented the hospital's P&P related to the IV administration set replacement**

**Policy and Procedure:**
The Chief Nursing Officer and Clinical Quality Improvement reviewed hospital policy titled Clinical Guidelines Venous Access Device Prevention Insertion and Maintenance and confirmed no revisions to the policy were required (FVR NUR 2.0).
Completion Date: 12/6/2022

**Corrective Action/Training:**
Upon notification of the survey finding, the Director of Clinical Quality Improvement and Clinical Education created education on the Clinical Guidelines Venous Access Device Prevention Insertion and Maintenance policy requirements. The re-education focused on ensuring expiration dates are clearly written on the IV tubing label that shows the frequency of changing the tubing based on the P&P. The Registered Nurses were re-educated via assigned mandatory online learning modules with attestations, deployed 12/12/2022, with evidence of 90% compliance by 01/12/2023. Any employee who was unable to be re-educated due to leave of absence or absenteeism will be re-educated upon return to work and prior to their first shift in assignment.
Completion Date: 01/12/2023

**Monitoring:**
The Clinical Directors or designee will conduct random audits on (n=5 or 100%) daily via patient room rounding to confirm all IV tubing have been labeled and expiration dates clearly visible. Any identified variance will be addressed during huddles, and 1:1 remediation with involved staff. Monitoring will occur until 3 consecutive months at 90% compliance is achieved. After 3 consecutive months at 100%

compliance, the audits will continue, at least quarterly, to confirm the sustainability of the corrective actions. Data will be tracked and trended for process improvement initiatives and reported up to Executive Nurse Council , Quality Patient Care Committee, Medical Executive Committee and Governing Board at their regularly scheduled meetings for review and action as required
Start Date: 01/12/2023 and ongoing.

**Disciplinary Action:**
Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.

**Responsible Person(s):**
Chief Nursing Officer

**3. Failure to ensure the nursing staff implemented the Hospital's P&P related to Skin and Wound Care**

**Policy and Procedure:**
The Chief Nursing Officer and the Clinical Quality Improvement reviewed hospital policy titled Wound and Skin Care Guidelines, Management and Documentation and confirmed no revisions to the policies were required (FVR NUR 113.0).
Completion Date: 12/6/2022

**Corrective Action/Training:**
Upon notification of the survey finding, the Directors of Nursing and Clinical Education created education on the Wound and Skin Care Guidelines, Management and Documentation policy requirements. The re-education focused on documentation of turning and repositioning every two hours, skin assessment documentation, wound photo documentation per policy and procedure. Registered Nurses were educated via assigned mandatory online learning modules with attestations, deployed 12/12/22 with evidence of 90% compliance by 01/12/23. Any employee who was unable to be re-educated due to leave of absence or absenteeism will be re-educated upon return to work and prior to their first shift in assignment
Completion Date: 01/12/2023

**Monitoring:**
The Clinical Directors or designee will conduct 30 medical record audits -monthly to confirm proper documentation of Q2 turning, skin assessments and skin photos with all the above requirements. Monitoring will occur until 3 consecutive months at 90% compliance is achieved. After 3 consecutive months at least 90 compliance, the auditing will continue quarterly to confirm sustainability of corrective action. Data will be tracked and trended for process improvement initiatives and reported up to Executive Nurse Council , Quality Patient Care Committee, Medical Executive Committee and Governing Board at their regularly scheduled meetings for review and action as required.
Start Date: 01/12/2023 and ongoing.

**Disciplinary Action:**

Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.

**Responsible Person(s):**
Chief Nursing Officer

**4. Failure to ensure the nursing staff implemented the hospital's P&P related to the use of restraints.**

**Policy and Procedure:**
The Chief Nursing Officer, Director of Patient Safety, and Director of Clinical Quality Improvement, reviewed hospital policy titled Restraint and Seclusion (CLN.02.06) and confirmed no revisions to the policy were required.
Completion Date: 12/6/2022

**Corrective Action/Training:**
1. Upon notification of the survey finding, the Director of Clinical Quality Improvement and Clinical Education created education on the Restraint and Seclusion policy requirements. The re-education focused on complete nursing assessment documentation every 2 hours. All Registered Nurses were re-educated via assigned mandatory online learning modules with attestations, deployed 12/12/2022, with evidence of 100% compliance by 01/12/2023. Any employee who was unable to be re-educated due to leave of absence or absenteeism will be re-educated upon return to work and prior to their first shift in assignment.
   Completion Date: 01/12/2023

2. Upon notification of the survey findings, the Chief of Staff and the Director of Clinical Quality Improvement created a memo with survey findings to share with medical staff. There was a focus documentation in the physicians charting for the need of continued restraints and ensuring that an order for continued restraint renewal was ordered in the Electronic Medical Record (EMR).
   Completion Date: 12/06/2022

**Monitoring:**

1. The Director of Clinical Quality Improvement or designee will conduct 100% medical record audits on (n=100%) for 30 days to confirm complete documentation with restraint utilization per policy. After 30 days, monitoring will occur monthly until 100% compliance is achieved. Data will be tracked and trended for process improvement initiatives and reported up to Nursing Executive Committee, Quality Patient Care Committee, Medical Executive Committee and Governing Board at their regularly scheduled meetings for review and action as required
2. The Director of Clinical Quality Improvement or designee will conduct medical record audits (n=100%) for 30 days to confirm renewal order is present and there is documentation the EMR. After 30 days, monitoring will occur monthly until 100% compliance is achieved. Data will be tracked and trended for process improvement initiatives and reported up to Nursing Executive Committee, Quality

Patient Care Committee, Medical Executive Committee and Governing Board at their regularly scheduled meetings for review and action as required
Start Date: 12/22/2022 and ongoing.

**Disciplinary Action:**
Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.

**Responsible Person(s):**
Chief Nursing Officer

**Tag A 410**

**1. Failed to ensure the medical staff provided quality of care - Did not accurately complete the medical records**

**Policy and Procedure:**
The Chief Nursing Officer, The Director of Clinical Quality Improvement, and the Chief of Staff reviewed hospital policy titled FVR BB 115.0 Documentation: Transfusion Information and Consent and FVR NUR 15.0 Blood and Blood Product: Obtaining a specimen, Obtaining Blood from Blood Bank; Administration of Blood Product; Monitoring the Patient and confirmed no revisions to the policies were required.
Completion Date: 12/6/2022

**Corrective Action/Training:**
Upon notification of the survey findings, the Chief of Staff and the Clinical Quality Director created a memo with survey findings to share with medical staff. There was a focus on Blood Transfusion consents having the MD signature, date and time. All CMS Validation Survey findings will be discussed at the next MEC meeting on 01/19/2023
Completion Date: 12/6/2022

Upon notification of the survey finding, Clinical Education created education on Consent and Blood and Blood Product: Obtaining a specimen, Obtaining Blood from Blood Bank; Administration of Blood Product; Monitoring the Patient Policy with a focus on implementing timely blood transfusion protocols; documenting 2 RN signatures, start time, vital signs, and completion time. The re-education was provided to the nurses in all nursing units via assigned mandatory online learning modules with attestations, deployed 12/12/2022 and 100% completion by 01/12/2023. Any employee unable to be re-educated due to leave of absence or absenteeism will be re-educated upon return to work and prior to their first shift in assignment.
Completion Date: 01/12/23

**Monitoring:**
The Director of Quality or designee will audit 30 blood transfusion consents monthly to verify it is dated, timed, and signed by the physician.

The Clinical Directors or designee will conduct random medical record audit. The audits will comprise of 30 charts review monthly to confirm timely initiation of blood transfusion, documentation of 2 RN signature on the blood transfusion record, start time of transfusion, vital sign documentation, and completion time of transfusion.

Monitoring will occur for 3 consecutive months until 100% compliance is achieved. After 3 months at 100 compliance, audits will be performed at least quarterly to confirm sustainability of corrective action. Data will be tracked and trended for process improvement initiatives and reported up to Executive Nurse Council , Quality Patient Care Committee, Medical Executive Committee and Governing Board at their regularly scheduled meetings for review and action as required.
Start Date: 01/12/23

**Disciplinary Action:**
Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.

**Responsible Person(s):**
Chief of Staff and Chief Nursing Officer

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**Tag A 700**

1. **Physical Environment - Failure to maintain safe and sanitary environment**
2. **Failure to maintain temp and humidity of exam room in OB**

**Policy and Procedure:**
The Chief Operating Officer, Chief Nursing Officer, Director of Patient Safety, Director of Clinical Quality Improvement, and Director of Plant Operations reviewed hospital policy titled FVR ADM 101.0 Temperature and Humidity Monitoring and confirmed no revisions to the policy were required.
Completion Date: 12/05/2022

**Corrective Action/Training:**
1. The Governing Board requested the Chief Operating Officer and the Chief Nursing Officer require at the monthly Governing Board meeting an Environment of Care report be presented. Information will be presented and discussed to provide recommendations to promote a safe and sanitary environment.
   Completed: 01/12/2022 and ongoing

2. Upon notification of the survey finding, immediate corrective action included addition of exam room to daily checks by engineering. Director of Plant Operations ensured the area will be monitored. The Director of Plant Operations educated 100% of the Engineering department via a staff meeting on 12/12/2022 and an attestation of knowledge was obtained from all staff members and any employee who was unable to attend due to leave of absence or absenteeism will be completed by 01/12/2023 or upon return prior to their first shift in assignment.
   Completed: 12/12/2022

**Monitoring:**
1. To closely oversee the sustained effectiveness of the changes and training accomplished, the Director of Clinical Quality Improvement implemented monitoring to take place surrounding each of the units. This monitoring will be reported to Executive Nurse Council , Quality Patient Care Committee, the Medical Executive Committee, and the Governing Board at their regularly scheduled meetings until compliance has been achieved for three months. These indicators will be monitored at least quarterly to confirm sustainability of the corrective actions. The indicators to be monitored are described throughout the body of this plan of correction.
2. The Temperature/Humidity daily checks are completed by the Engineering Department on a daily basis. The Facilities staff checks Temperature / Humidity logs daily and reports the results to the Director of Clinical Quality Improvement. The Director of Plant Operations is responsible for ensuring continued compliance with daily monitoring. Data will be tracked and trended for process improvement initiatives and reported up to Chief Operations Officer, Medical Executive Committee and Governing Board for review and action as required.
   Start Date: 12/12/2022 and ongoing.

**Disciplinary Action:**
Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.

**Responsible Person(s):**
Chief Operating Officer

**Tag A 701**

**Policy and Procedure:**
The Chief Operating Officer, Chief Nursing Officer, and the Director of Clinical Quality Improvement, Infection Prevention, and Director of Plant Operations reviewed hospital policies related to physical environment including the following:

- Infection Prevention Annual Plan
- Control Medical Equipment Management Plan (FVR EOC 132.0) and confirmed no revisions to the policy were required.
- Warming of Blankets (FVR ADM 56.0)
- Pest Control (FVR EOC 169.0)
- FVR EOC 177.0 Safe Use of Electrical Equipment
- Fire Precautions within Oxygen Enriched Environments Oxygen in Use Precautions (FVR EOC 86.0)

Completion Date: 12/05/2022

**Corrective Action/Training:**

1. The outdoor glass patio door will have a closing mechanism added for secure closure of the door.
   Completion Date: 12/12/2022

2. Upon notification of the survey finding, the Director of Intensive Care Unit re-educated staff on environment of care policy requirements including not having doors propped open through huddles and staff meetings.
   Completion Date: 12/12/2022

3. Upon notification of the survey finding, the Directors of Nursing, Infection Control, and Clinical Education created education on appropriate infection control and environment of care practices including the following:
   - Oxygen tanks secured in carrier
   - Broken furniture and equipment repaired or tagged and removed from service
   - Appropriate cleaning of patient equipment
   - Standard precaution requirements
   - Fire extinguisher mounted and secured
   - Separation of clean and dirty Supplies
   - Emergency equipment plugged into emergency backup power outlet
   - Maintain a clean and sanitary environment in the staff break room and nursing station areas
   - Replacement of stained ceiling tiles with placement of work order
   - Rusty equipment removed from service and placement of work order for chipped laminate or damaged cabinetry

- Contact Environmental Services for pest control service, if needed
- Patient Equipment free of tape and tape residue
- Storage of Food in designated areas
- Maintain a clean and sanitary environment in all clinical areas. Contact EVS for any issues.
- Linen and trashed will be placed in appropriate receptacle with a lid and tied closed. Contact Environmental Services for additional trash receptacles and for trash removal
- Maintaining a clutter free hallway
- Maintain refrigerator and freezer temperatures within range and document on daily log and place a work order if out of range.
- Maintain blanket warmer within temperature range and document on daily log and place a work order if out of range
- Expired supplies removed from service
- Sharps containers secured on wall and emptied when over the full line
- Items are not stored on the floor
- Ice will not be maintained in buckets for use
- Current preventive maintenance for equipment will be maintained. Call biomed if outdated PM is identified

All re-education content referenced above was provided to the hospital staff via assigned mandatory online learning modules with attestations, deployed 12/12/2022 with evidence of 100% compliance by 01/12/2023. Any employee who was unable to be re-educated due to leave of absence or absenteeism will be re-educated upon return to work and prior to their first shift in assignment

Upon notification of the survey finding, the Director of Clinical Quality Improvement and the Hospital Safety Officer revised the Environment of Care checklist for clinical units to include all elements of the plan of correction providing a safe and secure environment. The revised form was distributed to department leaders to perform daily Environment of Care rounds and address any non-compliant issues identified. A status update will be reported daily at the Leadership huddle. Validation rounds will be completed weekly by Quality and Infection Control.

Work orders will be placed for all facility issues (for example; chipped laminate, broken equipment, and stained ceiling tiles). Work Orders will be discussed and reviewed at daily huddle until resolution. The Chief Operating Officer will oversee and validate the prioritization process.

4. The Director of Environmental Services, Engineering, and Clinical Quality Improvement completed an assessment of the utilization and cleanliness of all showers in the organization. All showers were cleaned by Environmental Services upon notification of the survey finding. The schedule was revised and a mechanism was developed to document the daily completion of cleaning. The Director of Environmental Services or designee will re-educate staff on cleaning procedure per policy.

As needed, additional resources at the Regional/Hospital level will be used to assist with Engineering and Environmental needs.
Completion Date: 01/12/2023

**Monitoring:**

The Director of Clinical Quality Improvement or designee will maintain a daily compliance report of issues identified on units from the daily leadership meeting for the first 30 days to confirm compliance. After 30 days, monitoring will occur weekly. The Director of Quality or designee aggregates the data, analyzes for patterns and trends, performance and data will be tracked and trended for process improvement initiatives and reported up to Operations Executive, Medical Executive Committee and Governing Board for review and action as required.
Start Date: 12/06/2022

The Director of Environmental Services or designee will observe 25 patient showers weekly to validate the effectiveness of EVS cleaning. Auditing will continue until 3 months of 100% compliance is achieved. The results of the audits will be reported to the Quality Patient Care Committee and Medical Executive Committee as part of the performance improvement plan. After 3 consecutive months at 100% compliance, the audits will continue quarterly to confirm the sustainability of the corrective actions. Data will be tracked and trended for process improvement initiatives and reported up to Executive Nurse Council , Quality Patient Care Committee, Medical Executive Committee and Governing Board at their regularly scheduled meetings for review and action as required
Start Date: 12/12/2022 and ongoing.

**Disciplinary Action:**
Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.

**Responsible Person(s):**
Chief Nursing Officer and Chief Operating Officer

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**Tag A 726**

**Policy and Procedure:**
The Chief Nursing Officer, Chief Operating Officer, Director of Patient Safety, Director of Clinical Quality Improvement, Director of Women and Children's Services, and the Director of Plant Operations, reviewed hospital policy titled Management of Temperature, Humidity and Air Pressure Relationships (FVR ADM 101.0) and confirmed no revisions to the policy were required.
Completion Date: 12/5/2022

**Corrective Action/Training:**
1. The Director of Plant Operations added the OB special procedures room to the Temperature and Humidity (T&H) daily log. Engineering staff responsible for the daily temperature and Humidity monitoring were educated that the OB special procedure room was added to the daily log.
2. In addition, the Director of Women and Children's Services educated the staff to notify when temperature and humidity is out of range that corrective action is taken.

Completion Date: 12/12/2022

**Monitoring:**
The Director of Clinical Quality Improvement or designee will review the temperature and humidity log daily to verify when temperature and humidity is out of range that corrective action has been documented. Monitoring will occur until 3 consecutive months at 100% compliance is achieved. After 3 consecutive months at 100, the auditing will continue at least quarterly to confirm sustainability of corrective actions. Data will be tracked and trended for process improvement initiatives and reported to the Executive Nurse Council , Quality Patient Care Committee, Medical Executive Committee and Governing Board at their regularly scheduled meetings for review and action as required.
Start Date: 12/12/2022 and ongoing.

**Disciplinary Action:**
Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.

**Responsible Person(s):**
Director of Women and Children's Services, Director of Plant Operations