DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
San Francisco Regional Office
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Refer to: WDSC-mc

July 12, 2021

Administrator
Good Samaritan Hospital
2425 Samaritan Drive
San Jose, CA 95124

Re: CMS CertificationNumber 050380
Complaint No. CA00737098
Conditions of Participation Not Met
Removal of Deemed Status, 90-Day Termination Track

Dear Administrator:

Section 1865 of the Social Security Act (the Act) and Centers for Medicare & Medicaid Services (CMS) regulations provide that a provider or supplier accredited by a CMS-approved Medicare accreditation program will be "deemed" to meet all of the Medicare Conditions of Participation (CoPs) for hospitals. In accordance with Section 1864 of the Act State Survey Agencies may conduct at CMS's direction surveys of deemed status providers/suppliers on a selective sampling basis, in response to a substantial allegation of noncompliance, or when CMS determines a full survey is required after a substantial allegation survey identifies substantial noncompliance. CMS uses such surveys as a means of validating the accrediting organization's survey and accreditation process.

A survey conducted by the California Department of Public Health at Good Samaritan Hospital on June 14, 2021 found that the facility was not in substantial compliance with the following CoPs for hospitals.

42 C.F.R. § 482.12 Governing Body
42 C.F.R. § 482.21 QAPI
42 C.F.R. § 482.23 Nursing Services

As a result, effective the date of this letter, your deemed status has been removed and survey jurisdiction has been transferred to the California Department of Public Health.

A listing of all deficiencies found is enclosed (Form CMS-2567, Statement of Deficiencies and Plan of Correction.).

When a hospital, regardless of whether it has deemed status, is found to be out of compliance with the CoPs, a determination must be made that the facility no longer meets the requirements for participation as a provider or supplier of services in the Medicare program. Such a determination has been made in the case of Good Samaritan Hospital and accordingly, the Medicare agreement between Good Samaritan Hospital and CMS is being terminated.

The date on which the Medicare agreement terminates is October 12, 2021.

The Medicare program will not make payment for services furnished to patients who are admitted on or after October 12, 2021. For inpatients admitted prior to October 12, 2021, payment may continue to be made for a maximum of 30 days of inpatient services furnished on or after October 12, 2021.

Termination can only be averted by correction of the deficiencies, through submission of an acceptable plan of correction (PoC) and subsequent verification of compliance by the California Department of Public Health. The Form CMS 2567 with your POC, dated and signed by your facility's authorized representative must be submitted to CDPH no later than 10 days from the date you received this letter. Please indicate your corrective actions on the right side of the Form CMS-2567 in the column labeled "Provider Plan of Correction", and list the corresponding deficiency number in the column to its left, labeled "ID Prefix Tag". Additionally, indicate your anticipated completion dates in the column labeled "Completion Date".

An acceptable PoC must contain the following elements:

1. The plan for correcting each specific deficiency cited;

2. The plan for improving the processes that led to the deficiency cited, including how the hospital is addressing improvements in its systems in order to prevent the likelihood of recurrence of the deficient practice;

3. The procedure for implementing the PoC, if found acceptable, for each deficiency cited;

4. A completion date for correction of each deficiency cited;

5. The monitoring and tracking procedures that will be implemented to ensure that the PoC is effective and that the specific deficiency(ies) cited remain corrected and in compliance with the regulatory requirements; and

6. The title of the person(s) responsible for implementing the acceptable PoC.

Copies of the Form CMS-2567, including copies containing the facility's PoC, are releasable to the public in accordance with the provisions of Section 1864(a) of the Act and 42 CFR 401.133(a). As such, the PoC should not contain personal identifiers, such as patient names, and you may wish to avoid the use of staff names. It must, however, be specific as to what corrective action the hospital will take to achieve compliance, as indicated above.

Your facility will be revisited to verify necessary corrections. If CMS determines that the reasons for termination remain, you will be so informed in writing, including the effective date of termination. If corrections have been made and your facility is in substantial compliance, the termination procedures will be halted, and you will be notified in writing.

If your Medicare agreement is terminated and you wish to be readmitted to the program, you must demonstrate to the CDPH and CMS that you are able to maintain compliance. Readmission to the program will not be approved until CMS is reasonably assured that you are able to sustain compliance.

If you have any questions regarding this matter, please contact the CMS San Francisco Regional Office by phone at 415-744-3727 or by e-mail at Maureen.Calacal@cms.hhs.gov.

Sincerely,

Renae Hill

Renae Hill
Manager
Acute & Continuing Care Branch
San Francisco & Seattle

Enclosures: CMS Form-2567 Statement of Deficiencies

CC: State Survey Agency
Accrediting Organization

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050380	A. BUILDING_____ B. WING_____	C 06/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN HOSPITAL	2425 SAMARITAN DRIVE SAN JOSE, CA 95124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPIRATE DEFICIENCY)	(XS) ANTICIPATED COMPLETION DATE
A 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a complaint validation survey conducted from 6/7/21 to 6/14/21. The hospital was licensed for 404 beds and the census at the time of the survey was 219. The sample size was 37. For Complaint CA00737098 regarding Nursing Services, three Conditions of Participation were not met (42 CFR §482.12 Governing Body, §482.21 Quality Assessment and Performance Improvement Program [QAPI], and §482.23 Nursing Services) and federal deficiencies were identified. Inspection was limited to the specific Conditions of Participation authorized by CMS (Governing Body, Patient's Rights, Quality Assessment and Performance Improvement Program (QAPI), and Nursing Services). Representing the California Department of Public Health: 32999, Health Facilities Evaluator Supervisor; 33583, Health Facilities Evaluator Supervisor; 36045, Health Facilities Evaluator Supervisor; 41149, Health Facilities Evaluator Nurse; 38174, Evaluator Manager I; and, 41149, Medical Consultant.	A 000	Initial Comments The leadership of Good Samaritan Hospital take quality and patient safety very seriously as does the governing body. On identification of compliance issues, Good Samaritan Hospital leadership immediately convened to identify contributing factors, including oversight of the identified issues. Policies and procedures were reviewed and updated, as required. The following Plan of Correction has been developed in collaboration with Good Samaritan Hospital Leaders including the Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer, Medical Staff Leadership, and BOT CALIFORNIA DEPARTMENT OF PUBLIC HEALTH JUL 30 2021 L & C DIVISION SAN JOSE	
A 043	GOVERNING BODY CFR(s): 482.12 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 ... This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure compliance with all Conditions of Participation. This resulted	A 043	A 043 1 Title of Person Responsible for Corrective Action and Monitoring: Chief Executive Officer (CEO) and Chief Nursing Officer (CNO) Corrective Actions Taken: At the time of the onsite visit and with the receipt of findings, the Chief Executive Officer communicated the Statement of Deficiencies to the governing body on 7/13/2021 and to the medical staff on 7/19/2021.	6/15/2021 7/13/2021 7/19/2021

7/30/21

7/30/21 per Attached, JW

A 043	Performance Improvement Program). The governing body failed to fully address serious, systemic, and recurring issues, placing 13 of 37 sampled patients at risk for adverse events. Findings: 1. Failure to ensure that nursing services were provided to meet the needs of patients (refer to A-0385). 2. Failure to carry out an effective, system-wide quality assessment and performance improvement program (refer to A-0263). The governing body failed to implement an effective system that provided for oversight of staffing and maintenance of a safe environment for all patients. These cumulative failures resulted in the hospital's inability to endure patient safety and quality of care.	A 043	Title of Person Responsible for Corrective Action and Monitoring: CEO, CNO and BOT Corrective Actions Taken: Prior to the survey, nursing leaders requested travel nurses to augment staffing to prevent out of ratio occurrences. Director of ICU meets daily with ancillary departments of OR and Cath Lab to review scheduled cases to ensure appropriate staffing in intensive care units. Staff schedules are reviewed in advance to identify any staffing needs and calls are put out to find staff who are available to come in to fill the gap. Travelers, contract registry, float pool nurses are also potential sources of additional staff. Systemic Changes Implemented to Prevent Recurrence: Surge plan revised to anticipate elective procedures and compare to staffing schedules. If staffing is not sufficient then we reschedule elective procedures. We instruct the Transfer Center to defer ICU admissions until staffing can meet the demand. Daily during multi-disciplinary rounds and when possible, ICU patients are downgraded and transferred to a lower level care unit. Case Management also identify patients who need repatriation, SNF/ Rehab level of care after discharge to expedite transfers. Nursing supervisors assess staffing each hour to anticipate staffing needs and escalate to respective manager, director and CNO/AOD. This action plan was reviewed with and approved by the BOT on 7/20/2021. Measurable Goals: 100% compliance with staffing ratios in ICU. Denominator is the number of shifts, the numerator is the number of shifts we are in ratio. Monitoring Plan, Reporting Timeframes & Channels: The Staffing Ratios are reviewed at scheduled staffing calls (4 times daily and prn) and documented twice daily on the Nursing Supervisor's report. Auditing will be performed until 100% is achieved and sustained for 4 months. Auditing results will be reported to the QIC, MEC and BOT. We are currently at 100% compliance for ICU staffing.	6/18/2021 7/20/2021

A 043		A 043	Title of Person Responsible for Corrective Action and Monitoring: CNO Corrective Actions Taken: 6/16/2021 during the survey staffing reports reviewed to ascertain if each unit had a nurse leader scheduled for each shift. House Supervisors, charge nurses and CNCs instructed to ensure there is a nursing leader assigned for each shift. In the event staffing cannot be met, the issue is escalated to the manager, director, CNO/Admin on Call. Systemic Changes Implemented to Prevent Recurrence: Reviewed and revised Surge Plan to ensure resources are provided to coordinate patient care, monitor and coordinate unit operations, assess staffing needs for current census/ acuity, as well as the needs of the oncoming shift. (Available on Site-AOS) 100% of House supervisors, Directors, Managers, CNCs / Charge Nurses trained on staffing, Surge Plan and escalation processes. Reviewed and revised Plan for Provision of Patient Care to clarify staffing for each unit to ensure resources are provided to coordinate patient care, monitor and coordinate unit operations, and assess staffing needs for current census/ acuity. (AOS) Reviewed core staffing for each unit and requested positions to fill vacancies to be able to staff to Core (number of nurses to staff for full census). Additional actions included: Set up mandatory 2-hour trainings for each CNCs on staffing to ensure understanding and compliance with ensuring charge nurses/CNCs scheduled. Those on PT or FMLA will receive education prior to resuming their work. Developed standard call log for all units. Developed attestation/ competency sign-off related to Code Green and Out of Ratio escalation, bed huddle process with script, and documentation of texts/calls to fill short staffed shifts.	6/16/2021 6/18/2021 BOT 7/20/2021 BOT 7/20/2021 6/22/2021 7/8/2021 7/7/2021 7/7/2021

A 043		A 043	Measurable Goals: 100% of nursing units will have charge nurse/CNC available on each shift. We are currently 100% compliant Monitoring Plan, Reporting Timeframes & Channels: Charge Nurse staffing is audited daily. Denominator is number of nursing units; numerator is number of charge nurses available for each unit. If a charge nurse/CNC is unavailable, an alternate nursing leader will be identified. Auditing results will be reported to the QIC, MEC and BOT, monthly until sustained results 100% 4 months then quarterly. Title of Person Responsible for Corrective Action and Monitoring: CNO Corrective Actions Taken: During the survey on 6/9/2021 contacted Facilities to inquire about the central monitoring processes for refrigerators. Notified VP Ops that escalation alerts were not being automatically sent and contacted vendor. 6/9/21 Reports requested for all NICU refrigerators. 6/15/21 Unit secretaries manually monitoring NICU refrigerators hourly to ensure no alarms have been generated. Refrigerator now on Temp Trak and 100% in range currently. Systemic Changes Implemented to Prevent Recurrence: Until system generated alerts can be obtained, any out of range temperatures will be reported to the charge nurse who will take corrective actions, including documentation. Ultimately the system will continuously monitor the refrigerator temperature and generate a text alert to the unit secretary if any NICU refrigerator goes out range. 7/14/21 NICU policy on Breast Milk storage updated to define actions to be taken when/if refrigerator is out of range. Staff will be educated on this policy. We are currently at 100% compliance.	6/9/2021 6/152021 6/15/2021 7/14/2021

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SAN JOSE

A 043		A 043	Measurable Goals: A Daily report is run for any out of range temperatures on NICU refrigerators and to evaluate appropriate follow up. Numerator is the number of NICU breast milk refrigerators that have corrective documentation if found out of range: denominator is the total number of breast milk refrigerators that were out of range: goal 100% Monitoring Plan, Reporting Timeframes & Channels: Refrigerators currently being monitored hourly until the system capabilities are enabled. Auditing results will be reported to the QIC, MEC and BOT, monthly until sustained results 100% 4 months then quarterly. Title of Person Responsible for Corrective Action and Monitoring: CNO Corrective Actions Taken: 6/14/2021 During the survey, assignment sheets were revised to clearly indicate outpatient vs inpatient assignments. Systemic Changes Implemented to Prevent Recurrence: Created separate inpatient and outpatient assignment sheets to ensure no nurse is providing care to inpatients and outpatients simultaneously. 100% Staff educated that any outpatient procedures (e.g., infusion, car seat challenge) need to have a dedicated outpatient nurse. Measurable Goals: Nursing Dir / designee conducts daily audit of staffing assignment sheets performed to ensure outpatient services are provided by dedicated nursing staff 100% of the time. Denominator is number of outpatient services provided and the numerator is number outpatient nurses assigned. Monitoring Plan, Reporting Timeframes & Channels: Daily audits are performed: auditing results will be reported to the QIC, MEC and BOT monthly until sustained results 100% 4 months then quarterly.	6/14/2021

A 043		A 043	Title of Person Responsible for Corrective Action and Monitoring: CNO Corrective Actions Taken: Staff competencies pulled and reviewed for all ED RNs. Plan developed to ensure each RN had EVD training and competencies. Systemic Changes Implemented to Prevent Recurrence: Plan developed to ensure that each licensed nursing staff in the department will have proper training on the care of the patients with an external ventricular drain. (EVD) Plan includes each ED RN will be assigned 3 educational training videos using the hospital's computer-based training application. Following completion of the educational videos, each RN will take a written test via computer to validate successful understanding of learned materials. Each RN will also sign an attestation of receipt of information and knowledge of care of the patient with an external ventricular drain (EVD). We are currently at 100% compliance for those caring for patients. Measurable Goals: 100 % of ED RNs will demonstrate competence in caring for the patient with an external ventricular drain through return skills demonstration/signature validation of designated qualified educators/trainer (AOS). This includes orientation of new team members. Denominator is the total number of ED nurses in the department; the numerator is number of ED nurses who have successfully completed EVD training. Monitoring Plan, Reporting Timeframes & Channels: Monitoring and tracking will occur using generated electronic completion reports on a monthly basis to ensure compliance of 100% completion for each RN. Monitoring will be reported to QIC, MEC and BOT monthly until sustained results 100% for 4 months then quarterly. Title of Person Responsible for Corrective Action and Monitoring: Chief Nursing Officer Corrective Actions Taken: Worked with nursing supervisors to identify all sitter needs in the hospital. Deployed qualified staff to cover patient needs.	6/14/21 7/16/2021 8/06/2021 6/14/2021

A 043		A 043	Systemic Changes Implemented to Prevent Recurrence: A sitter float pool has been created to ensure sitter availability. Sitter positions have been posted to recruit and fill to meet needs. Nursing Supervisors assess sitter needs several times each shift and discuss in Charge nurse huddles. Any variance in sitter availability will be escalated immediately to ACNO/CNO. Measurable Goals: 100% of patients who need a sitter will have one. Dominator will be number total sitter patients, numerator will be number of total sitter staff. This is monitored daily. We are currently at 100% Monitoring Plan, Reporting Timeframes & Channels: Audits will be reported to Patient Safety Committee, QIC, MEC, BOT monthly until sustained results 100% for 4 months then quarterly. Title of Person Responsible for Corrective Action and Monitoring: CNO Corrective Actions : ICU Leadership reviewed incident and medical record to identify documentation deficiency. Follow up with ICU staff during shift huddles and through auditing to remind staff to ensure vital signs are time-stamped and downloaded into the critical care flow sheet that is imbedded in the eMAR. Systemic Changes Implemented to Prevent Recurrence: Immediate actions: Audits were conducted ICU patients who were on IV drip audits were implemented 6/22/21 to validate vital signs are present on the eMAR. Long-term: Work with Clinical Informatics to explore automating vital sign time-stamp capabilities. Measurable Goal 100% compliance with documenting vital signs in the eMAR. Denominator is the number of patients in ICU who are on IV drips; numerator the number of patients who have vital signs documented.	7/14/2021 06/22/2021

A 043		A 043	Monitoring Plan, Reporting Timeframes / Channels: Audit Results will be presented to QIC, MEC and BOT monthly until sustained results 100% for 4 months then quarterly. A 043 2 Title of Person Responsible for Corrective Action and Monitoring: Chief Medical Officer &Patient Safety Director Corrective Actions Taken: Education plan for emergency department (ED) and behavioral health unit (BHU) staff developed education assigned in HealthStream related to adverse events for 5150 patients. Education included, Observation requirements for a 5150 patient, when the use of restraints is appropriate, 5150 patients must never be left alone, handling of patient belongings, use of appropriate hospital attire, and conducting safety checks. Education for employees caring for BHU patients was completed on July 20, 2021.	7/20/2021
			During the survey, a single source document for tracking all serious event analysis (SEA) action items was created and implemented for on-going use. The document was populated on June 15, 2021 to include all SEAs from 2021. Tracking form will serve as report to Quality Improvement, Medical Executive Committee and Board of Trustees. Tracking tool will provide measure of success, required percentage to demonstrate compliance, and evaluation of sustainability upon completion action item for duration set.	6/15/2021
			Systemic Changes Implemented to Prevent Recurrence: 1. Review effectiveness of actions implemented on the 2 referenced cases 2. Developed a single-source document that includes event date/type, root cause, action items, responsible leaders, measures of success, due date for completion of action item(s) and oversight committee. 3. Provide learning from adverse events utilizing one or combination of the following (but not limited to) newsletters, fliers, staff meetings, one-on-one, huddles, health streams, coaching, direct observation, town halls.	7/13/2021

A 043		A 043	4. New event reporting system implemented on 7/13/21 has capability to provide feedback to staff pertaining to the outcome of event findings. 5. Ensure out of ratio events are entered into the event reporting system. 6. For each out of ratio event the evaluation of the patient outcome and care provided by the nurse out of ratio will be evaluated by the nursing leader and reported to patient safety. 7. Audit every out of ratio instance to ensure no patient safety event 100% of time. Numerator: Number of safety events on unit/shift for Out-of-Ratio instances Denominator: Number of Out-of-Ratio instances Monitoring Plan, Reporting Timeframes / Channels: Above actions will be incorporated into the QAPI program, reported monthly to the QIC, MEC, and BOT. Measurable Goals: • Audit areas at risk for similar events in the hospital where learning was required to be extended until 95% is documented. Numerator: Number of areas where learning was extended Denominator: Number of areas where learning was required to be extended • Education for ED and BHU staff and other vulnerable areas (3CVE, 3CVW, 3Med, CVICU, NSICU, ARU, Peds will be completed for 95% of department employees. Numerator: Number of employees completed Health stream assignment, Denominator: Total number of employees who had Health stream course assigned. This will be part of new employee orientation/competency. Monitoring Plan, Reporting Timeframes / Channels: Above actions will be incorporated into the QAPI program, reported monthly to QIC, MEC, and BOT monthly until sustained results 100% for 4 months then quarterly. The CNO will report monthly updates to the QIC, MEC, BOT on any out of ratio occurrence and staffing updates with actions taken to mitigate.	8/6/2021

A 043		A 043	Title of Person Responsible for Corrective Action and Monitoring: COO & VP Operations Corrective Action: The medical gas and elevator contracts were reviewed by the Administrative leader. Evaluation of the contracts was completed on 7/14/21, utilizing the approved contract evaluation form which includes department name, vendor name, reviewer(s) name, adverse events, complaints, performance measurements selected, and overall satisfaction. Performance measures selected could include, audit documentation, collection of data related to the service, direct observation of the service, input from staff and physicians, patient satisfaction studies, review of performance reports in the contract, review of incident reports, or all of the above. The contracted services were deemed effective, appropriate and have provided services outlined within the contract. Contract evaluations were presented and approved by the Medial Executive Committee (MEC) on 7/14/2021 and the Board of Trustees (BOT) on 7/20/2021. Systemic Changes Implemented to Prevent Recurrence: To ensure for continued compliance, the elevator and medical gas contracts have been added to the hospital's contract management list and will be included in the annual evaluation of contracts processes. Measurable Goals: 100% of the contracts will be evaluated annually and presented to BOT. Denominator is number of contracts; numerator is number of contracts reviewed annually by the BOT. Monitoring Plan, Reporting Timeframes / Channels: Contract evaluations will be presented to Quality Improvement Committee (QIC), MEC and BOT on an annual basis. Title of Person Responsible for Corrective Action and Monitoring: Chief Medical Officer Corrective Actions Taken: The Chief Executive Officer communicated the deficiencies to the governing body on 7/13/2021.	7/14/2021 7/14/2021 7/20/2021 7/13/2021

A 043		A 043	Corrective Actions Taken: Education plan for emergency department (ED) and behavioral health unit(BHU) staff developed education assigned in HealthStream related to adverse events for 5150 patients. Education included, Observation requirements for a 5150 patient, when the use of restraints is appropriate, 5150 patients must never be left alone, handling of patient belongings, use of appropriate hospital attire, and conducting safety checks,). Education was completed on July 20, 2021.	7/20/2021
			During the survey, a single source document for tracking all serious event analysis (SEA) action items was created and implemented for on-going use. The document was populated on June 15, 2021 to include all SEAs from 2021. Tracking form will serve as report to Quality Improvement, Medical Executive Committee and Board of Trustees. Tracking tool will provide measure of success, required percentage to demonstrate compliance, and evaluation of sustainability upon completion action item for duration set.	6/15/2021
			Systemic Changes Implemented to Prevent Recurrence: 1.Review effectiveness of actions implemented on the 2 referenced cases 2.Developed a single-source document that includes event date/type, root cause, action items, responsible leaders, measures of success, due date for completion of action item(s) and oversight committee. 3.Provide learning from adverse events utilizing one or combination of the following (but not limited to) newsletters, fliers, staff meetings, one-on-one, huddles, health streams, coaching, direct observation, town halls. 4.New event reporting system implemented on 7/13/21 has capability to provide feedback to staff pertaining to the outcome of event findings. 5.For each out of ratio event the evaluation of the patient outcome and care provided by the nurse out of ratio will be evaluated by the nursing leader and reported to patient safety. 7.Out of ratio events related to staffing will be evaluated to ensure appropriate escalation processes are followed.	7/13/2021
			Measurable Goals: •Audit event reports to determine if any additional events related to 5150 patients until 100% cases had no recurrence. Numerator: Number of event reports not related to 5150 patients Denominator: Number of all event reports	

A 043		A 043	•Audit areas at risk for similar events in the hospital where learning was required to be extended until 95% is documented. Numerator: Number of areas where learning was extended Denominator: Number of areas where learning was required to be extended •Audit every out of ratio instance to ensure an event report 100% of time. Numerator: Number of event reports for Out-of-Ratio instances Denominator: Number of Out-of-Ratio instances •Education for ED and BHU staff and other vulnerable areas (3CVE, 3CVW, 3Med, CVICU, NSICU, ARU, Peds will be completed for 95% of department employees. Numerator: Number of employees completed Health stream assignment, Denominator: Total number of employees who had Health stream course assigned	8/6/2021
A 084	CONTRACTED SERVICES CFR(S): 482.12(e)(1) The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to inform the governing body about two contracted services during the annual contract review. This deficient practice resulted in the governing body being unable to evaluate whether the contracted services were provided in a safe and effective manner to patients. Findings: During a review of the hospital's List of Contracts (2020), undated, revealed 375 contracts but did not include the medical gas contract or the elevator contract. During a review of the Quality Improvement Committee meeting minutes for 11/5/20,	A 084	A 084 Title of Person Responsible for Corrective Action and Monitoring: VP Operations Corrective Action: The medical gas and elevator contracts were reviewed the Administrative leader. Evaluation of the contracts was completed on 7/14/21, utilizing the approved contract evaluation form which includes department name, vendor name, reviewer(s) name, adverse events, complaints, performance measurements selected, and overall satisfaction. Performance measures selected could include, audit documentation, collection of data related to the service, direct observation of the service, input from staff and physicians, patient satisfaction studies, review of performance reports in the contract, review of incident reports, or all of the above. The contracted services were deemed effective, appropriate and have provided services outlined within the contract. Contract evaluations were presented and approved by the Medial Executive Committee (MEC) on 7/14/2021 and the Board of Trustees (BOT) on 7/20/2021. Report will be provided to BOT for their review and approval.	7/14/2021 7/14/2021 7/20/2021

A 084	indicated 375 contracted services were discussed. During a review of the Board of Trustees meeting minutes for 11/18/2020, revealed the annual review of physician and services contracts was presented to the governing body, with the number of contracted services documented as 375. During a review of the medical gas contract, effective 1/15/19, indicated the hospital was on the list of existing medical gas purchasers. During a review of the elevator contract, effective 11/1/2016 and expiring 10/31/21, indicated the hospital was on the list of purchasing facilities. During an interview on 6/9/21 at 2:14 p.m. with the Vice President of Operations (VPOP), the VPOP stated the hospital's typical procedure is to evaluate contracts annually. The VPOP stated all contracts on the List of Contracts (2020) undergo annual evaluations by the hospital. During a concurrent interview and document review on 6/9/21 at 9:33 a.m. with the VPOP, the VPOP confirmed the medical gas contract was not on the List of Contracts (2020) because it was a contract maintained by corporate. The VPOP stated the medical gas contract was not included in contract evaluation presentations to the Quality Improvement Committee or the Board of Trustees. When asked how the governing body would know if the medical gas vendor was performing to a satisfactory level, the VPOP stated "we would let them know if there were issues." The VPOP stated the hospital's corporate-maintained contracts are not downloaded onto the List of Contracts (2020). When asked how the hospital knows which corporate-maintained contracts are relevant to the hospital, the VPOP stated the corporate office tells them. The VPOP stated corporate performs the medical gas contract evaluation and asks for feedback from the hospital. When asked if the hospital receives the medical gas contract evaluation from corporate, the VPOP stated no, the hospital just receives information if there are any vendor issues with other corporate-owned facilities. When asked if the hospital's governing body receives any information about the medical gas contract evaluation from corporate, the VPOP stated only if there are issues. During a concurrent interview and document review on 6/9/21 at 12:09 p.m. with the VPOP,	A 084	Systemic Changes Implemented to Prevent Recurrence: To ensure for continued compliance, the elevator and medical gas contracts have been added to the hospital's contract management list and will be included in the annual evaluation of contracts processes. This will also be incorporated into the QAPI program. We have obtained a list of additional corporate contracts. A review is currently underway to identify all patient-related contracts. This will be completed by 8/6/2021. After any patient-related contracts have been identified, then we will evaluate the services and forward to the BOT for approval. Measurable Goals: 100% of the contracts will be evaluated annually and presented to BOT. Denominator is number of contracts; numerator is number of contracts reviewed annually by the BOT. Monitoring Plan, Reporting Timeframes / Channels: Contract evaluations will be presented to Quality Improvement Committee (QIC), MEC and BOT on an annual basis.	8/6/2021

A084	the VPOP confirmed the List of Contracts (2020) was the list of all hospital contracts with evaluations. When asked if the hospital has a way to access the corporate evaluation of the medical gas vendor, the VPOP stated no. During a concurrent interview and document review on 6/9/21 at 1:35 p.m. with the VPOP, the VPOP confirmed the elevator contract was not on the List of Contracts (2020) because it was a contract maintained by corporate. The VPOP stated the elevator contract has not undergone formal annual contract evaluations at the hospital level, and the elevator contract has only been discussed with the governing body if an issue affecting patient care came up. When asked if there was a way to find out what other corporate-maintained contracts are clinically relevant to the hospital, the VPOP stated it would be very time-consuming and he did not have that information right now. During a review of the hospital's Bylaws Governing the Board of Trustees, reviewed 11/19, Article 6.6.2 revealed "... The Board shall ensure that contracted services are performed safely and effectively through implementation of the performance improvement program ...".			
A 085	CONTRACTED SERVICES CFR(s): 482.12(e)(2) The hospital must maintain a list of all contracted services, including the scope and nature of the services provided. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to maintain a complete and accurate list of contracted services. This deficient practice had the potential for the hospital to be unaware of which contracted services were in effect. Findings: During a review of the hospital's List of Contracts (2020), undated, revealed 375 contracts but did not include the medical gas contract or elevator contract. During a review of the Quality Improvement Committee meeting minutes for 11/5/20, indicated there were 375 contracted services.	A 085	A 085 Title of Person Responsible for Corrective Action and Monitoring: COO & VP Operations Corrective Action: The medical gas and elevator contracts were reviewed by the Administrative leader. Evaluation of the contracts was completed on 7/14/21, utilizing the approved contract evaluation form which includes department name, vendor name, reviewer(s) name, adverse events, complaints, performance measurements selected, and overall satisfaction. Performance measures selected could include, audit documentation, collection of data related to the service, direct observation of the service, input from staff and physicians, patient satisfaction studies, review of performance reports in the contract, review of incident reports, or all of the above. The contracted services were deemed effective, appropriate and have provided services outlined within the contract. Contract evaluations were presented and approved by the Medial Executive	7/14/2021 7/14/2021 7/20/2021

A 085	During a review of the Board of Trustees meeting minutes for 11/18/2020, revealed the annual review of physician and services contracts was presented to the governing body, with the number of contracted services documented as 375. During an interview on 6/8/21 at 2:10 p.m. with the Regulatory and Accreditation Manager (RAM), the RAM confirmed the hospital has a medical gas vendor. During a review of the medical gas contract, effective 1/15/19, indicated the hospital was on the list of existing medical gas purchasers. During a review of the elevator contract, effective 11/1/2016 and expiring 10/31/21, indicated the hospital was on the list of purchasing facilities. During a concurrent interview and document review on 6/9/21 at 9:33 a.m. with the Vice President of Operations (VPOP), the VPOP confirmed the medical gas contract was not on the List of Contracts (2020) because it was a contract maintained by corporate. The VPOP stated the hospital's corporate-maintained contracts are not downloaded onto the List of Contracts (2020). When asked how the hospital knows which corporate-maintained contracts are relevant to the hospital, the VPOP stated the corporate office tells them. During a concurrent interview and document review on 6/9/21 at 1:35 p.m. with the VPOP, the VPOP confirmed the elevator contract was not on the List of Contracts (2020) because it was a contract maintained by corporate. When asked if there was a way to find out what other corporate-maintained contracts are clinically relevant to the hospital, the VPOP stated it would be very time-consuming and he did not have that information right now. During an interview on 6/9/21 at 12:09 p.m. with the VPOP, when asked if the List of Contracts (2020) was a complete list of contracted services, the VPOP stated no. During a review of the hospital's Bylaws Governing the Board of Trustees, reviewed 11/19, Article 6.6.3 revealed"... The Board shall require that the hospital maintain a list of all contracted services ...".	A085	Committee (MEC) on 7/14/2021 and the Board of Trustees (BOT) on 7/20/2021. Report will be provided to BOT for their review and approval. Systemic Changes Implemented to Prevent Recurrence: To ensure for continued compliance, the elevator and medical gas contracts have been added to the hospital's contract management list and will be included in the annual evaluation of contracts processes. Corporate contracts will be included in the annual review by the BOT. We have obtained a list of additional corporate contracts. A review is currently underway to identify all patient-related contracts. This will be completed by 8/6/2021. After any patient-related contracts have been identified, then we will evaluate the services and forward to the BOT for approval. Measurable Goals: 100% of the contracts will be evaluated annually and presented to BOT. Denominator is number of contracts; numerator is number of contracts reviewed annually by the BOT. Monitoring Plan, Reporting Timeframes / Channels: Contract evaluations will be presented to Quality Improvement Committee (QIC), MEC and BOT on an annual basis. Should a contractor performance issue arise, this will be brought through these channels and escalated as well as corrective actions or termination of the contract.	8/6/2021

A 092	EMERGENCY SERVICES CFR(s): 482.12(f)(1) If emergency services are provided at the hospital, the hospital must comply with the requirements of §482.55. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to implement its policy when emergency technician B's (ET B) competency was not validated prior to her working in the hospital. This failure had the potential for an unqualified staff to provide care to patients. Review of ET B's Sitter Competency and Tech Competency Validation documents, dated 6/9/2021, indicated ET B signed these forms on 6/9/2021. During an interview with the nurse interim director in emergency department (NIDED) on 6/10/2021 at 10:45 a.m., the NIDED stated ET B transferred from an affiliate hospital and was hired on 1/28/2021. The NIDED stated ET B's competency validation records were unavailable upon hire to this hospital. The NIDED stated there was no evidence that ET B's competency was validated before she started work at this hospital. During an interview on 6/11/2021 at 9:50 a.m., the Human Resources Vice President (HRVP) stated unit leaders should validate employees' competencies before they start working on the units. Review of the hospital's policy, "Employee Records Policy," dated 1/1/2015, indicated the purpose was to established standards by which information was managed in employee records in order to achieve accuracy, privacy and compliance (e.g. legal, regulatory, or accreditation compliance). Review of the hospital's policy, "Competency Assessment Policy," dated 8/10/2020, indicated the purpose was to define mechanisms used to assess and maintain competency of Colleagues, as required for the position and by regulatory agencies. It stated pre-employment assessment included validation of training required by the job I description. The initial competency assessment included, at a minimum, the validation of core competencies specific to the role and responsibility of each position.	A 092	A 092 Title of Person Responsible for Corrective Action and Monitoring: CNO Corrective Actions Taken: During the survey on 6/9/21 the ED Tech completed her unit-based competencies and were verified through various validation methods such as return demonstration, teach back, etc. In addition, the ED Tech's initial competencies from affiliate hospital were obtained on 6/11/21 and presented to the surveyors. Systemic Changes Implemented to Prevent Recurrence: During the survey, the ED Director in collaboration with the ED educator established a process to ensure competency validation by the ED Director or leadership designee will occur prior to the employee's completion of department orientation and before employee is assigned independent work in the department. ED Director or leadership designee verified that employee's competencies have been reviewed and completed. Measurable Goals: Monthly audits will be conducted to ensure 100% of newly hired ED Techs will have completed competencies before employee functions independently and is assigned work in the department. The denominator is the number of scheduled ED Techs; the numerator the number of scheduled ED Techs that have completed competencies. Monitoring Plan, Reporting Timeframes & Channels: Audits will be performed monthly and reported to QIC, MEC, and BOT monthly until sustained results 100% for 4 months then quarterly. The department is currently in 100% compliance with this process.	6/9/2021 6/11/2021 8/6/2021

A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on interview and record review, the hospital failed to carry out its Quality Assessment and Performance Improvement program when the following occurred: 1. Failure to assess corrective action plan for effectiveness or sustainability after one adverse patient event (refer to A-0286). 2. Failure to assess corrective action plan for sustainability after one adverse patient event (refer to A-0286). 3. Failure to extend learning from two adverse patient events to other areas of the hospital at risk for similar events (refer to A-0286). 4. Failure to recognize the potential for or track actual negative patient care outcomes that occurred during staffing shortages, failure to revise action plan for staffing shortages despite repeated occurrences, and failure to relay staffing shortage occurrences and negative patient care outcomes to the governing body (refer to A-0286). 5. Failure to evaluate two contracted services at the hospital level and to relay this information to the governing body (refer to A-0308). These cumulative failures resulted in the hospital's inability to ensure provision of quality care in a safe environment, as required by the Quality Assessment and Performance Improvement Program Condition of Participation.	A263	A 263 Title of Person Responsible for Corrective Action and Monitoring: Chief Medical Officer and Patient Safety Director Corrective Actions Taken: Education plan for emergency department (ED) and behavioral health unit (BHU) staff developed education assigned in HealthStream related to adverse events for 5150 patients. Education included, Observation requirements for a 5150 patient, when the use of restraints is appropriate, 5150 patients must never be left alone, handling of patient belongings, use of appropriate hospital attire, and conducting safety checks. Education for employees caring for BH patients was completed on July 20, 2021 for active staff. This training is also being provided to other clinical areas of the hospital that may be involved in the care of patients experiencing a mental health emergency. The date of completion for this is 8/6/2021. After this date, any staff members who have not had the education must complete the module prior to the start of their next shift or they will not be allowed to work. Content and attendance for this education is AOS. During the survey, a single source document for tracking all serious event analysis (SEA) action items was created and implemented for on-going use. The document was populated on June 15, 2021 to include all SEAs from 2021. Tracking form will serve as report to Quality Improvement, Medical Executive Committee and Board of Trustees. Tracking tool will provide measure of success, required percentage to demonstrate compliance, and evaluation of sustainability upon completion action item for duration set. Systemic Changes Implemented to Prevent Recurrence: 1. Review effectiveness of actions implemented on the 2 referenced cases. 2. Developed a single-source document that includes event date/type, root cause, action items, responsible leaders, measures of success, due date for completion of action item(s) and oversight committee. 3. Provide learning from adverse events utilizing one or combination of the following (but not limited to) newsletters, fliers, staff meetings, one-on-one, huddles, health streams, coaching, direct observation, town halls. Performance improvement opportunities identified through the serious event analysis process will be	7/20/2021 8/6/2021 6/15/2021

A 263		A 263	disseminated to all appropriate departments and staff for extended learning. 4. Following education of employees and physicians during June and July, a new event reporting system implemented on 7/13/2021 that has capability to provide feedback to staff pertaining to the outcome of event findings. When staff open the link to the event reporting system, they receive an electronic thank you message to reinforce the importance of reporting safety events and near misses. Appreciation of their contribution to the safety culture by speaking up and reporting is also offered. Additionally, an email is sent to the staff member after they enter an event report (excluding staff who have chosen to enter the report anonymously) with instructions on how to check back on the status of the reported event. 5. Ensure out of ratio events are entered into the event reporting system. • Out of ratio events are escalated to the CNO and AOC for immediate attention, action. Active engagement prior to shifts occurs 24/7 days a week to avoid out of ratio. Staff call out is the primary source of occurrences to cover shifts. These are called out during the Safety Huddle to ensure all are aware and appropriate actions taken. Nursing will maintain a log and report, as required to CDPH. • If and when an out of ratio event occurs, Quality will work with leaders to ensure no adverse events occurred, as reported through the Vigilanz system. Staffing is already a component of any SEA event. 6. For each out of ratio event the evaluation of the patient outcome and care provided by the nurse out of ratio will be evaluated by the nursing leader and reported to patient safety. 7. Audit every out of ratio instance to ensure no patient safety event 100% of time. Numerator: Number of safety events on unit/shift for Out-of-Ratio instances; Denominator: Number of Out-of-Ratio instances Measurable Goals: • Expanded Learning: Audit areas at risk for similar events in the hospital where learning was required to be extended until 100% is documented. Numerator: Number of areas where learning was extended Denominator: Number of areas where learning was required to be extended • Education for ED and BHU staff and other vulnerable areas (3CVE, 3CVW, 3Med, CVICU, NSICU, ARU, Peds will be completed for 100% of	7/13/2021 8/6/2021 8/6/2021

A 263		A 263	department employees. Numerator: Number of employees completed Health stream assignment, Denominator: Total number of employees who had Health stream course assigned. This will be part of new employee orientation/competency. Monitoring Plan, Reporting Timeframes / Channels: Above actions will be incorporated into the QAPI program, reported monthly to the QIC, MEC, and BOT. The CNO will report monthly updates to QIC, MEC and BOT on any out of ratio occurrence and staffing updates with actions taken to mitigate.	
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to fully implement its Quality Assessment and Performance Improvement program when 1. The corrective action plan after one adverse patient event did not assess for effectiveness or sustainability.	A 286	A 286 Title of Person Responsible for Corrective Action and Monitoring: Chief Medical Officer & VPQ Corrective Action: The corrective action plans for the adverse events were reviewed in detail as well as the follow-up on each. Systemic Changes Implemented to Prevent Recurrence: • Review effectiveness of actions implemented on the 2 referenced cases • Developed a single-source document that includes event date/type, root cause, action items, responsible leaders, measures of success, due date for completion of action item(s) and oversight committee. • Provide learning from adverse events utilizing one or combination of the following (but not limited to) newsletters, fliers, staff meetings, one-on-one, huddles, health streams, coaching, direct observation, town halls. Performance improvement opportunities identified through the serious event analysis process will be disseminated to all appropriate departments and staff for extended learning. • New event reporting system implemented on 7/13/2021 as part of Corporate Culture of Safety work, has capability to provide feedback to staff in real time and also allows medical staff input and anonymous reporting, if desired. When staff open the link to the event reporting system, they receive an electronic thank you message to reinforce the importance of reporting safety events and near misses. Appreciation of	7/13/2021

A 286	2. The corrective action plan after one adverse patient event did not assess for sustainability. 3. The learning from two adverse patient events was not rolled out to other areas of the hospital at risk for similar events. 4. The hospital did not recognize the potential for or track actual negative patient care outcomes that occurred during staffing shortages, did not revise its action plan for staffing shortages despite repeated occurrences, and did not relay staffing shortage occurrences and negative patient care outcomes to the governing body. These deficient practices had the potential to jeopardize the health and safety of patients. Findings: 1. During an interview on 6/8/21 at 8:27 a.m. with the Regulatory and Accreditation Manager (RAM), the RAM stated the hospital's root cause analyses (method used to analyze adverse events, which focuses on identifying underlying problems that increase likelihood of errors) are called serious event analyses (SEA). During an interview on 6/10/21 at 10:14 a.m. with the Director of Patient Safety and Risk Management (DPSRM), the DPSRM reviewed the SEA for an October 2020 adverse patient event in the Emergency Department (ED). The DPSRM stated a suicidal patient under a 5150 hold (a hold placed when a patient is a danger to self, others, or gravely disabled) harmed herself with a clothing item while alone in the bathroom. The DPSRM stated staff had opened the bathroom door to check on the patient every ten seconds. The DPSRM stated one root cause was staff feeling uncomfortable with taking the patient's belongings and clothing and putting the patient in a paper gown. The DPSRM stated the ED leadership educated staff about the department's 5150 policy through staff huddles. When asked if there was any other education provided, the DPSRM stated no. When asked if there was any auditing of ED staff interactions with 5150 patients after the provided education, either via direct observation or chart review, the DPSRM stated no. During a concurrent interview and document review on 6/10/21 at 3:57 p.m. with the DPSRM, the DPSRM provided the hospital's policy and procedure, "Patient Awaiting Psychiatric Evaluation in the Emergency Department", approved 01/22/2020. The DPSRM stated the	A 286	their contribution to the safety culture by speaking up and reporting is also offered. Additionally, an email is sent to the staff member after they enter an event report (excluding staff who have chosen to enter the report anonymously) with instructions on how to check back on the status of the reported event. • For each out of ratio event the evaluation of the patient outcome and care provided by the nurse out of ratio will be evaluated by the nursing leader and reported to patient safety for collaborative review. • Event reports related to staffing will be evaluated to ensure appropriate escalation processes are followed. Measurable Goals: • Audit areas at risk for similar events in the hospital where learning was required to be extended until 100% is documented. Numerator: Number of areas where learning was extended Denominator: Number of areas where learning was required to be extended. • A summary of all SEA process improvements / learnings and metrics will be reported to the QIC, MEC and BOT. Monitoring Plan, Reporting Timeframes / Channels: Above actions will be incorporated into the QAPI program, reported monthly to the QIC, MEC, and BOT monthly until sustained results 100% for 4 months then quarterly. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH	8/6/2021

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A 286	previous ED director, who was the director at the time of the adverse patient event, modified the policy and then educated the ED staff in huddles. When asked if there were huddle minutes, the DPSRM stated no. When asked if there was documentation of which staff attended the huddles, the DPSRM stated no and that should have happened. When asked if there was a quiz or method of validation after the huddles, the DPSRM stated he was not aware of any. When asked, without validation, how the hospital would know if its staff education was effective, the DPSRM stated he understood the need for tracking. During an interview on 6/14/21 at 11:19 a.m. with Registered Nurse F (RN F), RN F stated there are no sign-in sheets during staff huddles. During a concurrent interview and document review on 6/11/21 at 4:00 p.m. with the DPSRM, the DPSRM showed the Emergency Department SEA summary. The summary revealed the action plan for each of the three root causes was to modify the department's policy to guide staff on what to do when patients refuse to surrender personal items. The summary revealed the action plan's measure of success (MOS) was the completion of updates to the policy, and the MOS monitoring period was the distribution of the updated policy to ED staff. During a concurrent interview and document review on 6/10/21 at 4:31 p.m. with the DPSRM, the DPSRM showed the Emergency Department SEA summary. The DPSRM stated the distribution of the updated policy to ED staff referred to the education that took place during I the staff huddle. During an interview on 6/11/21 at 3:43 p.m. with the DPSRM and Registered Nurse C (RN C), RN C recalled the previous ED director providing education in a staff huddle after the ED patient adverse event. RN C stated the previous ED director told staff that all patients need their belongings removed and that patients need to wear paper scrubs. However, RN C stated it still was not clear what and how many personal items 5150 patients can keep with them. RN C also stated sometimes 5150 patients are allowed to lock the door while using the bathroom. RN C stated the ED staff needs more training about behavioral health patients. RN C stated some patients keep their mobile phone chargers with them, which can be used to harm themselves.	A 286		

A 286	When asked if there was any discussion about formal re-education of ED staff regarding 5150 patients after the patient adverse event, the DPSRM stated no, not that he was aware of. During a concurrent interview and document review on 6/14/21 at 9:32 a.m. with the DPSRM, the DPSRM showed the Emergency Department SEA summary. The DPSRM stated that all three root causes related to issues with staff knowledge, and that was why the previous ED director modified the department's 5150 policy and conducted staff huddles associated with the updated policy. When asked how the hospital was going to monitor the effectiveness and sustainability of the SEA action plan, the DPSRM stated "we saw it as education provided or not" and that he did not really have a good answer. The DPSRM stated there was no formal re-education of staff about 5150 patients, and that the hospital's online training program would have been a good platform for that. The DPSRM stated theoretically, beyond the huddles, they could have looked at monitoring. The DPSRM stated no sustainability process was built into the ED SEA action plan. During a review of the hospital's policy and procedure, "Serious Safety Event Identification, Notification and Management", approved 1/27/2021, indicated the hospital "... will utilize this policy following identification of a patient serious safety event ..." to" ... Implement established actions ... Monitor implementation, effectiveness and sustainability of actions ... Act when monitoring indicates actions are not effective and/or sustained ...". 2. During an interview on 6/8/21 at 8:27 a.m. with the Regulatory and Accreditation Manager (RAM), the RAM stated the hospital's root cause analyses (method used to analyze adverse events, which focuses on identifying underlying problems that increase likelihood of errors) are called serious event analyses (SEA). During an interview on 6/10/21 at 10:14 a.m. with the Director of Patient Safety and Risk Management (DPSRM), the DPSRM reviewed the SEA for an October 2020 adverse patient event in the inpatient psychiatry unit. The DPSRM stated a patient under a 5150 hold (a hold placed when a patient is a danger to self, others, or gravely disabled) was inappropriately discharged and harmed himself with an object in his possession while waiting for transportation.	A 286		

A 286	The DPSRM stated, after the adverse event, the inpatient psychiatry unit staff underwent education about the department's 5150 policy and a Skills Day. During a concurrent interview and document review on 6/11/21 at 10:37 a.m. with the Director of Behavioral Health (DBH), the DBH reviewed the inpatient psychiatry adverse patient event. The DBH stated the patient was inappropriately discharged. The DBH stated, after the adverse event, the department completed training for staff on how to discharge patients. During a concurrent interview and document review on 6/10/21 at 3:57 p.m. with the DPSRM, the DPSRM provided a document containing an emailed agenda and tests from the Skills Day. The email, dated 12/1/2020, instructed staff to log into the online Skills Day on 12/1/2020. The agenda included a review of the 5150 policy, a workflow for discharges, and a post-test. During a concurrent interview and document review on 6/14/21 at 9:32 a.m. with the DPSRM, the DPSRM showed the inpatient psychiatry SEA summary. The summary revealed two root causes. When asked if there was concern about staff knowledge of 5150 patients, the DPSRM stated yes, that this type of adverse event could happen again so the hospital wanted to make sure staff did not deviate from normalized processes. When asked if there was any auditing of staff, either via direct observation or chart review, after the Skills Day, the DPSRM stated no. The DPSRM stated the Skills Day was the completion of the SEA action plan, after which there were no other monitoring plans included in the SEA. During a concurrent interview and document review on 6/11/21 at 2:33 p.m. with the DPSRM and the DBH, the DBH stated he has been performing chart review of ten randomly selected patient charts every month since November 2020. When asked if there is data from the chart review, the DBH stated he reviews the data monthly and sends it to corporate but has not formally compiled it. The DBH stated he also directly observed a subset of physician discharges in December 2020 and January 2021. When asked if there is data for the physician discharges, the DBH stated no. The DBH stated he started the chart review and direct observations outside of the SEA action plan, and that he had not sent his chart review data to the hospital's Quality Department or the	A 286		

A 286	Quality Improvement Committee. The DPSRM confirmed the chart review and direct observation of physician discharges were not on the inpatient psychiatry SEA summary. During an interview on 6/14/21 at 10:34 a.m. with the DBH, the DBH stated the chart review tool he used did not contain questions specifically related to staff interactions with 5150 patients. When asked if, as part of the SEA process itself, there was any auditing of staff after the Skills Day, the DBH stated no. During a review of the hospital's policy and procedure, "Serious Safety Event Identification, Notification and Management", approved 1/27/2021, indicated the hospital"... will utilize this policy following identification of a patient serious safety event ..." to" ... Implement established actions ... Monitor implementation, effectiveness and sustainability of actions ... Act when monitoring indicates actions are not effective and/or sustained ...". 3. During an interview on 6/8/21 at 8:27 a.m. with the Regulatory and Accreditation Manager (RAM), the RAM stated the hospital's root cause analyses (method used to analyze adverse events, which focuses on identifying underlying problems that increase likelihood of errors) are called serious event analyses (SEA). During an interview on 6/10/21 at 10:14 a.m. with the Director of Patient Safety and Risk Management (DPSRM), the DPSRM reviewed the SEA for an October 2020 adverse patient event in the Emergency Department (ED). The DPSRM stated a suicidal patient under a 5150 hold (a hold placed when a patient is a danger to self, others, or gravely disabled) harmed herself with a clothing item while alone in the bathroom. The DPSRM stated staff had opened the bathroom door to check on the patient every ten seconds. The DPSRM stated one root cause was staff feeling uncomfortable with taking the patient's belongings and clothing and putting the patient in a paper gown. During a concurrent interview and document review on 6/14/21 at 9:32 a.m. with the DPSRM, the DPSRM showed the Emergency Department SEA summary. The DPSRM stated that all three root causes related to issues with staff knowledge. During an interview on 6/11/21 at 3:43 p.m. with the DPSRM and Registered Nurse C, RN C	A 286		

A 286	recalled the previous ED director providing education in a staff huddle after the ED patient adverse event. RN C stated the ED director told staff that all patients need their belongings removed and that patients need to wear paper scrubs. However, RN C stated it still sometimes 5150 patients are allowed to lock the door while using the bathroom. RN C stated the ED staff needs more training about behavioral health patients. RN C stated some patients keep their mobile phone chargers with them, which can be used to harm themselves. During a concurrent interview and document review on 6/11/21 at 4:00 p.m. with the DPSRM, the DPSRM showed the Emergency Department SEA summary. There was no discussion about rolling out the action plan to other areas of the hospital at risk for similar events. During an interview on 6/10/21 at 10:14 a.m. with the DPSRM, the DPSRM reviewed the SEA for an October 2020 adverse patient event in the inpatient psychiatry unit. The DPSRM stated a patient under a 5150 hold was inappropriately discharged and harmed himself with an object in his possession while waiting for transportation. During a concurrent interview and document review on 6/14/21 at 9:32 a.m. with the DPSRM, the DPSRM showed the inpatient psychiatry SEA summary. The summary revealed two root causes. When asked if there was concern about staff knowledge of 5150 patients, the DPSRM stated yes, that this type of adverse event could happen again so the hospital wanted to make sure staff did not deviate from normalized processes. During a concurrent interview and document review on 6/14/21 at 9:32 a.m. with the DPSRM, the DPSRM showed the inpatient psychiatry SEA summary. There was no discussion about rolling out the action plan to other areas of the hospital at risk for similar events. During an interview on 6/10/21 at 3:57 p.m. with the DPSRM, when asked if the learning from the Emergency Department and the inpatient psychiatry adverse patient events was extended to staff in other departments, the DPSRM stated no, the education was mainly focused on these two departments. During an interview on 6/10/21 at 10:14 a.m. with the DPSRM, when asked if 5150 patients	A 286		

A 286	are admitted to areas of the hospital besides the inpatient psychiatry unit, the DPSRM stated yes. During an interview on 6/11/21 at 12:06 p.m. with the Manager of the Neurosurgical Intensive Care Unit (MNSICU), the MNSICU confirmed that patients under a 5150 hold can be admitted to inpatient rooms located in units other than the inpatient psychiatry unit. During an interview on 6/11/21 at 3:43 p.m. with the DPSRM, when asked if there was any discussion about other departments and their staff being at risk for similar adverse events with 5150 patients, and whether the learning should be expanded to those departments, the DPSRM stated no. When asked if the ED and inpatient psychiatry patient adverse events both relate to staff interactions with 5150 patients, the DPSRM stated yes. During a review of the hospital's policy and procedure, "Serious Safety Event Identification, Notification and Management", approved 1/27/2021, indicated for patient serious safety events that"... Feedback to the organization as a whole is also essential to create a culture of safety and shared learning ...". 4. During an interview on 6/11/21 at 11:20 a.m. with the Director of the Intensive Care Unit (DICU), the DICU stated intensive care unit patients are classified by acuity levels from level one to level four. The DICU stated there is a ratio of one nurse to two patients for level one through level three patients, and a ratio of one nurse to one patient for level four patients. During a concurrent interview and record review on 6/9/21 at 8:33 a.m. with the Manager of the Neurosurgical Intensive Care Unit (MNSICU), the Neurosurgical Intensive Care Unit (NSICU) nursing staff assignment sheets were reviewed. The assignment sheets revealed one nurse was assigned three patients on 4/12/21 between 11:00 a.m. and 3:00 p.m.; two nurses were each assigned three patients on 5/4/21 between 3:00 p.m. and 7:00 p.m.; three nurses were each assigned three patients on 5/5/21 between 7:00 a.m. and 11:00 a.m.; two nurses were each assigned three patients on 5/5/21 between 11:00 a.m. and 7:00 p.m.; one nurse was assigned three patients on 5/9/21 between 3:00 p.m. and 7:00 p.m.; two nurses were each assigned three patients on 5/9/21 between 7:00 p.m. and 11:00 p.m.; and three nurses were each assigned	A 286		

A 286	three patients on 5/10/21 between 7:00 a.m. and 11:00 a.m. The MNSICU acknowledged the nurse-to-patient ratios were one nurse to three patients in the NSICU on 4/12/21, 5/4/21, 5/5/21, 5/9/21, and 5/10/21. were each assigned three patients on 5/5/21 between 7:00 a.m. and 11:30 a.m., and one nurse was assigned three patients on 5/7/21 between 7:00 a.m. and 11:30 a.m. The DICU acknowledged the nurse-to-patient ratios were one nurse to three patients in the CVICU on 5/5/21 and 5/7/21. During an interview on 6/14/21 at 2:29 p.m. with the Chief Nursing Officer (CNO), the CNO stated the hospital utilizes employed nurses, registry nurses, and traveler nurses for staffing. The CNO stated the hospital has a registry nurse group that provides registry nurses and traveler nurses. The CNO stated the house supervisors meet with the nurse leaders of each unit every four hours to discuss staffing. The CNO stated the house supervisors may request staffing from the registry nurse group at any time. The CNO stated if the nurse leader cannot find staffing for an upcoming shift, the issue is escalated to the unit manager, then the unit director, then to her as CNO. When asked if she was aware there were nurses caring for more patients than allowed by state nurse-to-patient ratios on 4/12/21 in the NSICU, the CNO stated yes. When asked what actions were taken when the nurses were out-of-ratio, the CNO stated the hospital called employed nurses and its registry nurse group to obtain more nurses, evaluated if any patients could be downgraded from the intensive care units (ICU), and evaluated if the hospital could close the ICU to incoming transfers or surgeries. When asked if she was aware there were nurses caring for more patients than allowed by state nurse – to - patient ratio on 5/4/21 in the NSICU the CNO stated yes when asked what actions were taken when the nurses were out-of-ratio, the CNO stated the hospital looked at ways to obtain more traveler nurses and more rapidly. When asked what actions were taken when the nurses were out-of-ratio in the CVICU on 5/5/21, the CNO stated the hospital pulled nurses from other patient care units. The CNO stated that after each out-of-ratio occurrence, her actions were the same calling in employed nurses, requesting registry and traveler nurses,	A 286		

A 286	downgrading patients, and evaluating surgery schedules. When asked what other actions were taken, the CNO stated the hospital has hired new staff and partnered with nursing schools to get nurses in. The CNO stated the hospital did not pivot quickly enough and thus was out-of-ratio on the previously mentioned days. When ask ed what actions the hospital took to prevent out-of-ratio occurrences from repeating, the CNO stated the hospital has a safety huddle every day, during which all managers, directors, and the executive team discuss staffing. When asked if there are meeting minutes for the executive team meetings, the CNO stated not since the previous Chief Executive Officer departed. When asked if the hospital has any protocols or guidelines for out-of-ratio occurrences, the CNO stated only its strategies to pivot. When asked if out-of-ratio occurrences or staffing issues were discussed beyond the executive team, the CNO stated she has given verbal reports to the Medical Executive Committee (MEC) and the Board of Trustees about staffing and what the hospital is doing to obtain more nurses. The CNO stated she did not recall bringing up specific out-of-ratio occurrences to either the MEC or the Board of Trustees. During an interview on 6/14/21 at 4:47 p.m. with the CNO and the Regulatory and Accreditation Manager (RAM), the CNO stated there was no documentation of any discussions or actions the executive team took to address the out-of-ratio occurrences. When asked if there was any evidence of actions taken at a systems level, the CNO stated there was no documentation. The CNO stated the executive team looked at the surgery schedule to see which surgeries could be cancelled, but she did not hear which cases were cancelled. The CNO stated the hospital did not have any guidelines outlining what to do when nurses are out-of-ratio. When asked if the hospital modified its strategies or action plan when out-of-ratio events occurred, the CNO stated she is evaluating strategies to see what did and did not work, and has requested more traveler nurses. During a concurrent interview and record review on 6/9/21 at 8:33 a.m. with the MNSICU, NSICU patient records were reviewed. One registered nurse (RN), assigned to three patients on 5/5/21,	A 286		

A 286	missed patient assessments for Patient 9, Patient 11, and Patient 12. One RN, assigned to three patients on 5/5/21, missed patient assessments for Patient 19. One RN, assigned to three patients on 5/9/21, missed patient assessments for Patient 9 and Patient 20. One RN, assigned to three patients on 5/9/21, missed patient assessments for Patient 10, Patient 17, and Patient 18. One RN, assigned to three patients on 5/10/21, missed patient assessments for Patient 9, Patient 19, and Patient 20. One RN, assigned to three patients on 5/10/21, missed patient assessments for Patient 14, Patient 21, and Patient 22. During a concurrent interview and record review on 6/10/21 at 1:00 p.m. with the MNSICU, NSICU patient records were reviewed. One RN, assigned to three patients on 5/5/21, did not titrate Patient S's nicardipine (a medication that lowers blood pressure) infusion as ordered by the physician, or notify a provider when the infusion was at zero milligrams/hour as ordered by the physician. One RN, assigned to three patients on 5/4/21 and on 5/5/21, did not document Patient 12's heart rate and blood pressure according to the physician order while Patient 12 was on an amiodarone (a medication used to treat abnormal heart rhythms) infusion. One RN, assigned to three patients on 5/5/21, did not document Patient 19's pain level according to the physician order while Patient 19 was on a fentanyl (a pain medication) infusion. One RN, assigned to three patients on 5/9/21, administered acetaminophen (a medication used to treat pain or fever) to Patient 20 for pain when the physician order, dated 5/8/21, indicated acetaminophen was to be administered as needed for temperature greater than 99 degrees Fahrenheit. During a review of QIC meeting minutes for 11/5/2020, indicated concern was expressed that issues with staffing were impacting safe quality of care. During a review of QIC meeting minutes for 5/6/2021, revealed concern that there were not enough nurses to take care of patients in the intensive care units and other units. Issues with two specific patients were brought up. A concern was also expressed that the transfer center should not accept additional patients because the hospital, due to significant staffing issues, did not have the capacity to care for them.	A 286		

A 286	During a review of the Board of Trustees meeting minutes for 1/27/2021, 3/24/2021, 4/28/2021, and 5/26/2021, indicated nurse recruitment and retention strategies were discussed. There was no discussion about specific out-of-ratio occurrences or negative patient outcomes related to short-staffing. During a concurrent interview and document review on 6/14/21 at 4:47 p.m. with the CNO and the RAM, the CNO stated she was not aware of multiple patient assessments being missed and medications not being administered according to physician orders while nurses were out-of-ratio. When asked if anyone assesses for potential patient care issues when there are out-of-ratio occurrences, the CNO stated her expectation is the nursing unit leaders would tell her if there were any concerns. The CNO stated there is no system in place to evaluate the nursing care provided during out-of-ratio shifts. When asked if the missed patient assessments or medication administration outcomes, or the potential for negative patient care outcomes, were brought up to the QIC, the MEC, or the Board of Trustees, the CNO stated she was not aware of these outcomes so she did not bring them up at these committee meetings. The CNO stated these negative patient care outcomes should have been brought up. The CNO stated when staffing issues were brought up at QIC meetings, she discussed open nurse positions and strategies to get more nurses. The CNO confirmed she was present at the 5/6/2021 QIC meeting. When asked if there was any further discussion about the staffing-related patient care concerns, the CNO stated there was no further discussion during or after the 5/6/2021 QIC meeting. During a concurrent interview and document review on 6/14/21 at 5:43 p.m. with the CNO, the CNO stated she did not follow-up regarding the staffing-related patient care concerns brought up at the 5/6/2021 QIC meeting. When asked if she brought up these patient care concerns to the MEG or the Board of Trustees, the CNO stated no, she only talked about open nurse positions and strategies to mitigate the hospital's staffing shortage. When asked if the potential for negative patient care outcomes and actual negative patient care outcomes related to staffing shortages were issues the MEG and the Board of Trustees should know about, the CNO stated yes.	A 286		

A 286	During a review of the hospital's Organizational Performance Improvement Plan 2021, approved 02/24/2021, revealed Quality Improvement Committee members"... Oversee and coordinate evaluation of all patient care and patient safety related activities hospital wide ... Reviewing data including ongoing indicators/trends ... Ensuring data is ... analyzed on an ongoing basis by trending of data ... Ensuring information from data is used to make changes that improve performance and patient safety and reduce risk of sentinel events ...". During a review of the hospital's Bylaws Governing the Board of Trustees, reviewed 11/19, Article 6.7 revealed"... The Board is ultimately responsible for the quality of patient care and services provided by the hospital... at least annually, a report to the board shall be presented [sic] regarding the occurrence of medical/healthcare errors and actions taken to approve patient safety, both in response to actual occurrences and proactively .... The board shall oversee the activities to improve organizational performance and patient safety insure that actions are taken appropriate to findings and that the outcomes of such actions are documented.	A 286		
A 308	QAPI GOVERNING BODY, STANDARD TAG CFR(s): 482.21 ... The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement) ... The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to inform the governing body about two contracted services during the annual contract review. This deficient practice resulted in the governing body being unable to evaluate whether the contracted services were provided in a safe and effective manner to patients. Findings: During a review of the hospital's List of Contracts (2020), undated, revealed 375 contracts but did not include the medical gas contract or the elevator contract.	A 308	A 308 Title of Person Responsible for Corrective Action and Monitoring: COO & VPOP Corrective Action: The medical gas and elevator contracts were reviewed by the Administrative leader. Evaluation of the contracts was completed on 7/14/2021, utilizing the approved contract evaluation form which includes department name, vendor name, reviewer(s) name, adverse events, complaints, performance measurements selected, and overall satisfaction. Performance measures selected could include, audit documentation, collection of data related to the service, direct observation of the service, input from staff and physicians, patient satisfaction studies, review of performance reports in the contract, review of incident reports, or all of the above. The contracted services were deemed effective, appropriate and have provided services outlined within the contract. Contract evaluations were presented and approved by the Medial Executive Committee (MEC) on 7/14/2021 and the Board of Trustees (BOT) on 7/20/2021. Report will be provided to BOT for their review and approval.	7/14/2021 7/14/2021 7/20/2021

A 308	During a review of the Quality Improvement Committee meeting minutes for 11/5/20, indicated 375 contracted services were discussed. During a review of the Board of Trustees meeting minutes for 11/18/2020, revealed the annual review of physician and services contracts was presented to the governing body, with the number of contracted services documented as 375. During a review of the medical gas contract, effective 1/15/19, indicated the hospital was on the list of existing medical gas purchasers. During a review of the elevator contract, effective 11/1/2016 and expiring 10/31/21, indicated the hospital was on the list of purchasing facilities. During an interview on 6/9/21 at 2:14 p.m. with the Vice President of Operations (VPOP), the VPOP stated the hospital's typical procedure is to evaluate contracts annually. The VPOP stated all contracts on the List of Contracts (2020) undergo annual evaluations by the hospital. During a concurrent interview and document review on 6/9/21 at 9:33 a.m. with the VPOP, the VPOP confirmed the medical gas contract was not on the List of Contracts (2020) because it was a contract maintained by corporate. The VPOP stated the medical gas contract was not included in contract evaluation presentations to the Quality Improvement Committee or the Board of Trustees. When asked how the governing body would know if the medical gas vendor was performing to a satisfactory level, the VPOP corporate-maintained contracts are not downloaded onto the List of Contracts (2020). When asked how the hospital knows which corporate-maintained contracts are relevant to the hospital, the VPOP stated the corporate office tells them. The VPOP stated corporate performs the medical gas contract evaluation and asks for feedback from the hospital. When asked if the hospital receives the medical gas contract evaluation from corporate, the VPOP stated no, the hospital just receives information if there are any vendor issues with other corporate-owned facilities. When asked if the hospital's governing body receives any information about the medical gas contract evaluation from corporate, the VPOP stated only if there are issues. During a concurrent interview and document review on 6/9/21 at 12:09 p.m. with the VPOP,	A 308	Systemic Changes Implemented to Prevent Recurrence: To ensure for continued compliance, the elevator and medical gas contracts have been added to the hospital's contract management list and will be included in the annual evaluation of contracts processes. We have obtained a list of additional corporate contracts. A review is currently underway to identify all patient-related contracts. This will be completed by 8/6/2021. After any patient-related contracts have been identified, then we will evaluate the services and forward to the BOT for approval. Measurable Goals: 100% of the contracts will be evaluated annually and presented to BOT. Denominator is number of contracts; numerator is number of contracts reviewed annually by the BOT. Monitoring Plan, Reporting Timeframes / Channels: Contract evaluations will be presented to Quality Improvement Committee (QIC), MEC and BOT on an annual basis. Should a contractor performance issue arise, this will be brought through these channels and escalated as well as corrective actions or termination of the contract.	7/23/2021 8/6/2021

A308	the VPOP confirmed the List of Contracts (2020) was the list of all hospital contracts with evaluations. When asked if the hospital has a way to access the corporate evaluation of the medical gas vendor, the VPOP stated no. During a concurrent interview and document review on 6/9/21 at 1:35 p.m. with the VPOP, the VPOP confirmed the elevator contract was not on the List of Contracts (2020) because it was a contract maintained by corporate. The VPOP stated the elevator contract has not undergone formal annual contract evaluations at the hospital level, and the elevator contract has only been discussed with the governing body if an issue affecting patient care came up. When asked if there was a way to find out what other Corporate-maintained contracts are clinically relevant to the hospital, the VPOP stated it would be very time-consuming and he did not have that information right now. During a review of the hospital's Bylaws Governing the Board of Trustees, reviewed 11/19, Article 6.6.2 revealed "... The Board shall ensure that contracted services are performed safely and effectively through implementation of the performance improvement program ...".	A 308		
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to comply with the Condition of Participation for Nursing Services as evidenced by: 1. Failure to provide nursing staff to meet Nurse-to-Patient ratios at 1:2 or fewer at all times in the intensive care units (refer to A-0392). 2. Failure to provide charge nurses every shift in each unit (refer to A-0392). 3. Failure to provide unexpired supplies (refer to A-0392 and A-0398). 4. Failure to keep a refrigerator within the acceptable temperatures (refer to A-0392).	A 385	A 385 1 Title of Person Responsible for Corrective Action and Monitoring: CNO Corrective Actions Taken: Prior to the survey nursing leaders requested travel nurses to augment staffing to prevent out of ratio occurrences. Director of ICU meets daily with ancillary departments of OR and Cath Lab to review scheduled cases to ensure appropriate staffing in intensive care units. Staff schedules are reviewed in advance to identify any staffing needs and calls are made to find staff who are available to come in to fill the gap. Travelers, contract registry, float pool nurses are also potential sources of additional staff, utilized as available to meet staffing needs. Systemic Changes Implemented to Prevent Recurrence: Surge plan revised to anticipate elective procedures and compare to staffing schedules. If staffing is not sufficient then we reschedule elective procedures. Upon notification and senior leader approval, the Transfer Center will defer ICU admissions until staffing can meet the demand.	6/18/2021 7/20/2021 BOT

A 385	5. Failure to designate outpatient nursing staff for outpatient services (refer to A-0392). 6. Failure to validate nursing staffs competency prior to providing care (refer to A-0397). 7. Failure to provide a sitter (refer to A-0392). 9. Failure to assess patients and document the assessment (refer to A-0398). 10. Failure to inspect emergency crash carts (refer to A-0398). 11. Failure to administer medications as ordered (refer to A-0405). The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the provision of quality health care in a safe environment.	A 385	Daily and during multi-disciplinary rounds and when possible, ICU patients are downgraded and transferred to a lower level care unit. Case Management also identify patients who need repatriation, SNF/ Rehab level of care after discharge to expedite transfers. Nursing supervisors assess staffing frequently to anticipate staffing needs and escalate to respective manager, director and CNO/AOD. Measurable Goals: 100% compliance with staffing ratios in ICU. Denominator is the number of shifts, the numerator represents the number of shifts we are in ratio. Monitoring Plan, Reporting Timeframes & Channels: The Staffing Ratios are reviewed at scheduled staffing calls (4 times daily and prn) and documented twice daily on the Nursing Supervisor's report. Auditing will be performed until 100% is achieved and sustained for 4 months. Audits will be reported to QIC, MEC, BOT monthly until sustained results 100% for 4 months then quarterly. We are currently in 100% compliance for ICU staffing. A 385 2 Corrective Actions Taken: 6/16/21 during the survey staffing reports reviewed to ascertain if each unit had a nurse leader scheduled for each shift. House Supervisors, charge nurses and CNCs instructed to ensure there is a nursing leader assigned for each shift. In the event staffing cannot be met, the issue is escalated to the manager, director, CNO/Admin on Call. Systemic Changes Implemented to Prevent Recurrence: Reviewed and revised Surge Plan to ensure resources are provided to coordinate patient care, monitor and coordinate unit operations, assess staffing needs for current census/ acuity, as well as the needs of the oncoming shift. 100% of House supervisors, Directors, Managers, CNCs / Charge Nurses trained on staffing, Surge Plan, and escalation processes. (AOS)	6/16/2021 6/18/2021 7/20/2021 BOT

A 385		A 385	Reviewed and revised Plan for Provision of Patient Care to clarify staffing for each unit to ensure resources are provided to coordinate patient care, monitor and coordinate unit operations, and assess staffing needs for current census/ acuity. (AOS) Reviewed core staffing for each unit and requested positions to fill vacancies to be able to staff to Core (number of nurses to staff for full census). Additional actions included: 100% of CNCs available participated in mandatory 2-hour trainings on staffing to ensure understanding and compliance with charge nurses/CNCs scheduled and escalation of issues/concerns. Those on PTO or FMLA will receive the education prior to resuming their work. Developed standard call log for all units. Developed attestation/ competency sign-off related to Code Green and Out of Ratio escalation, bed huddle process with script, and documentation of texts/calls to fill short staffed shifts. Measurable Goals: 100% of nursing units will have charge nurse/CNC available on each shift. Currently at 100% compliance Monitoring Plan, Reporting Timeframes & Channels: Charge Nurse staffing is audited daily. Numerator is number of charge nurse/ CNC assigned by unit. Denominator is number of total charge nurse/CNC expected to cover nursing units. If a charge nurse/CNC is unavailable, an alternate nursing leader will be identified to fill that role. Audits will be reported to QIC, MEC, BOT monthly until sustained results 100% for 4 months then quarterly. A 385 3 Immediate Actions Taken: 3 During the survey expired items were removed from the Broselow carts and replaced.	6/18/2021 7/20/2021 BOT 7/8/2021 7/7/2021 7/7/2021 6/11/2021

A 385		A 385	Systemic Changes to Prevent Recurrence: Centralized Equipment Distribution (CED) engaged to standardize the carts and start a cart exchange system. Every drawer has a list of items that it contains with the expiration dates. The drawer is sealed with breakaway plastic with the sheet of all items with the expiration dates. The expiration dates of all items are also put into a data-based application. This application has a barcode on each cart that when scanned will identify what items are expiring. Also, we have physically placed a label on the outside of every drawer that item that will be expiring with the soonest date. This is monitored daily and validated daily with nursing log sheets. There's now an extra cart for a Broselow cart exchange program. The Broselow cart exchange can be activated on i-mobile by any caregiver. CED will be checking all 6 Broselow carts to ensure carts are being check daily by nursing. If any cart has not been checked, nursing leadership is notified. If expired items are found, the drawer is replaced with a new seal. Currently at 100% MOS. Measurable Goals: 100% there will be no expired items on the Broselow. Through daily audits, Denominator is the number of Broselow carts, the numerator is the number of Broselow carts that have been checked and have no expired items. Monitoring Plans, Timeframes, & Reporting Channels: Cart audit results will be presented to QIC, MEC and BOT. monthly until 100% sustained for 4 months then quarterly. A 385 4 Actions Taken: During the survey on 6/9/2021 the unit director contacted Facilities to inquire about the central monitoring processes for refrigerators. Notified VP Ops that escalation alerts were not being automatically sent and contacted vendor. 6/9/21 Reports requested for all NICU refrigerators. 6/15/21 Unit secretaries manually monitoring NICU refrigerators hourly to ensure no alarms have been generated. Refrigerators now on Temp Trac. 100% in range currently Systemic Changes Implemented to Prevent Recurrence:	7/7/2021 6/9/2021 6/15/2021

A 385		A 385	Until able to monitor ongoing temperatures hourly for NICU with escalation for out of rand and follow Breast Milk policy. Any out of range temperatures will be reported to the charge nurse who will take corrective actions, including documentation. Other patient refrigerators are monitored per policy. Ultimately the system will continuously monitor the refrigerator temperature and generate a text alert to the unit secretary if any NICU refrigerator goes out range. 7/14/2021 NICU policy on Breast Milk storage updated to define actions to be taken when/if refrigerator is out of range. Staff will be educated on this policy. We are currently at 100% compliance. Measurable Goals: A Daily report is run for any out of range temperatures on NICU refrigerators for breast milk storage and to evaluate appropriate follow up. Numerator is the number of NICU breast milk refrigerators that have corrective documentation if found out of range: denominator is the total number of breast milk refrigerators that were out of range: goal 0% out of range. Monitoring Plan, Reporting Timeframes & Channels: NICU Refrigerators currently being monitored hourly. Auditing results will be reported to the QIC, MEC and BOT, monthly until sustained results 100% 4 months then quarterly. 385 5 Corrective Actions Taken: 6/14/2021 During the survey, assignment sheets were revised to clearly indicate outpatient vs inpatient assignments. Systemic Changes Implemented to Prevent Recurrence: Created separate inpatient and outpatient assignment sheets to ensure no nurse is providing care to inpatients and outpatients simultaneously. 100% Staff educated that any outpatient procedures (e.g., infusion, car seat challenge) need to have a dedicated outpatient nurse. Currently 100% compliance. Measurable Goals:	7/14/2021 6/14/2021

A 385		A 385	Nursing Director/designee conducts Daily audit of staffing assignment sheets performed to ensure outpatient services are provided by dedicated nursing staff 100% of the time. Denominator is number of outpatient services provided and the numerator is number outpatient nurses assigned. Monitoring Plan, Reporting Timeframes & Channels: Daily audits are performed: auditing results will be reported to the QIC, MEC and BOT monthly until 100% sustained performance for 4 months then quarterly. A 385 6 Corrective Actions Taken: Staff competencies viewed for all ED RNs (100%) Plan developed to ensure each RN had EVD training and competencies. Those staff on PTO or FMLA will complete prior to assignment. Systemic Changes Implemented to Prevent Recurrence: Plan developed to ensure that each licensed nursing (100%) staff in the department will have proper training on the care of the patients with an external ventricular drain. (EVD), including orientation of new team members. Plan includes each ED RN will be assigned 3 educational training videos using the hospital's computer-based training application. Following completion of the educational videos, each RN will take a written test via computer to validate successful understanding of learned materials. Each RN will also sign an attestation of receipt of information and knowledge of care of the patient with an external ventricular drain (EVD). Currently 100% complete for those caring for patients. Measurable Goals: 100 % of ED RNs will demonstrate competence in caring for the patient with an external ventricular drain through return skills demonstration/signature validation of designated qualified educators/trainer. (AOS) This includes orientation of new team members. Denominator is the total number of ED nurses in the department; the numerator is number of ED nurses who have successfully completed EVD training. Only staff that have demonstrated competency will care for the EVD patients. Monitoring Plan, Reporting Timeframes & Channels:	6/9/2021 6/15/2021 8/6/2021

A 385		A 385	Monitoring and tracking will occur using generated electronic completion reports on a monthly basis to ensure compliance of 100% completion for each RN. Monitoring will be reported to QIC, MEC and BOT monthly until 100% sustained performance for 4 months then quarterly. A 385 7 Corrective Actions Taken: Established methodology with nursing supervisors to identify all sitter needs in the hospital. Deployed qualified staff to cover patient needs. Systemic Changes Implemented to Prevent Recurrence: A sitter float pool has been created to ensure sitter availability. Sitter positions have been posted to recruit and fill to meet needs. Nursing Supervisors assess sitter needs several times each shift and discuss in Charge nurse huddles. Any variance in sitter availability will be escalated immediately to ACNO/CNO. Measurable Goals: 100% of patients who need a sitter will have one. Denominator will be number total sitter required patients; numerator will be number of total sitters assigned staff. This is monitored daily by Director of BH/designee. We are currently at 100% compliance. Monitoring Plan, Reporting Timeframes & Channels: Audits will be reported to Patient Safety Committee, QIC, MEC, BOT monthly until sustained results 100% for 4 months then quarterly. A 385 9 Corrective Actions : ICU Leadership reviewed incident and medical record to identify documentation deficiency. Follow up with ICU staff during shift huddles and through auditing to remind staff to ensure vital signs are time-stamped and downloaded into the critical care flow sheet that is imbedded in the eMAR. Systemic Changes Implemented to Prevent Recurrence: Immediate actions: Audits were conducted ICU patients who were on IV drip audits were	6/14/2021 7/14/2021 6/22/2021

A 385		A 385	implemented 6/22/21 to validate vital signs are present on the eMAR. Measurable Goal 100% compliance with documenting vital signs in the eMAR. Denominator is the number of patients in ICU who are on IV drips; numerator the number of patients who have vital signs documented. Monitoring Plan, Reporting Timeframes / Channels: Audit Results will be presented to QIC, MEC and BOT monthly until sustained results 100% for 4 months then quarterly. A 385 10 Corrective Actions Taken: 10 On 6/16/2021 OR Dir met with a Charge Nurse in PACU to discuss the expectation that a 24-hour inspection of crash carts will be performed and documented. On 6/16/2021 Began daily auditing in all units with 100% crash carts inspected for 24-hour inspection documentation by CNC and validation by Director of Surgical Services. On 6/27/2021 Began a weekly audit by directors of documented inspection of Crash Cart Log completion Systemic Changes Implemented to Prevent Recurrence: On 7/15/2021 a revised process was established to enhance daily audits daily rounding implemented by CED to include crash cart inspection monitoring. Coaching occurs for any variance with unit assigned staff/leaders. Measurable Goals: 100% compliance with inspection of each adult crash cart 100% compliance with inspection of each pediatric crash cart Monitoring Plan, Reporting Timeframes & Channels: • CED will perform daily inspections of adult/pediatric crash cart log until 100% is achieved and sustained for 4 months • Directors will perform weekly audits of the daily inspection of the adult/pediatric crash cart log until 100% is achieved and sustained for 4 months	6/16/2021 6/16/2021 6/27/2021 7/15/2021

A 385		A 385	• Compliance is reviewed daily to evaluate inspection of crash cart compliance and documentation. • Results will be reported to the QIC, MEC and BOT monthly until sustained results 100% for 4 months then quarterly. A 385 11 Corrective Actions: During the survey the patient's orders were reviewed and compared to the eMAR to ensure infusion titration accuracy. Systemic changes Implemented to Prevent Recurrence: All IV titratable drips are reviewed daily by charge nurses in the ICUs for physician order, parameters, rate on pump, guardrails on, and nurse following physician order(s), Physician orders are reviewed at the daily multidisciplinary rounds (which include pharmacists). Any duplicative orders will be identified and addressed with the physician. ICU Orders sets are being reviewed and revised. ICU nurses and clinical informatics to address all IV titratable medications to eliminate discrepancies and ensure accuracy. Measurable Goals: 100% IV titratable medications will be administered per physician orders. Initial sample of 10 drips/unit/shift ICU and then expand. Denominator is the number of patients on IV titratable drips each day, numerator is the number of patients receiving titratable drips as prescribed. Monitoring Plan, Reporting Timeframes & Channels: All patients receiving IV titratable medications are monitored every day. Audits will be present to Department of Critical Care, QIC, MEC and BOT until 100% sustained performance for 4 months then quarterly. We are currently at 100 % compliance.	6/11/2021 7/14/2021
A 392	STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b) 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	A 392	A 392 1 Title of Person Responsible for Corrective Action and Monitoring: CNO	

A 392	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. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to provide adequate nursing staff when: 1. Nurse-to-patient ratios exceeded 1:2 (ratio of one nurse to two patients) for five occurrences in the Neurosurgical Intensive Care Unit (NSICU) and two occurrences in the Cardiovascular Intensive Care Unit (CVICU). 2. Charge nurses were lacking for two out of 30 days in the CVICU, four out of 30 days in the NSICU, two out of 30 days in the Emergency Department, and once in the Labor and Delivery (L&D) unit. 3. Medications were not administered as ordered for four patients (Patients 8, 12, 19, and 20) when the nurse-to-patient ratios exceeded 1:2 (ratio of one nurse to two patients) in the NSICU. 4. In the Pediatric Unit (PED) and Pediatric Intensive Care Unit (PICU), patients were placed in the PICU regardless of their acuity, outpatients (patients who receive medical treatment without being admitted into a hospital) were placed in the PICU, and inpatient nurses provided outpatient services. One charge nurse was assigned to both units and, occasionally, charge nurses were unavailable. 5. In the Neonatal Intensive Care Unit (NICU), suction canisters were not changed because a unit technician was unavailable. The temperatures of a breast milk refrigerator were recorded out of acceptable ranges but no further actions were taken. 6. In the Telemetry unit, a sitter was unavailable when a patient required a sitter. 7. In the Labor and Delivery (L&D) unit, two nurses were unassigned to a patient. These failures had the potential to negatively impact the quality of patient care. Findings: 1. Review of nursing staff assignment sheets, with the Manager of Neurosurgical	A 392	Corrective Actions Taken: Prior to the survey, nursing leaders requested travel nurses to augment staffing to prevent out of ratio occurrences. Director of ICU meets daily with ancillary departments of OR and Cath Lab to review scheduled cases to ensure appropriate staffing in intensive care units. Staff schedules are reviewed in advance to identify any staffing needs and calls are put out to find staff to find staff who are available to come in to fill the gap. Travelers, contract registry, float pool nurses are also potential sources of additional staff. Systemic Changes Implemented to Prevent Recurrence: Surge plan revised to anticipate elective procedures and compare to staffing schedules. If staffing is not sufficient then we reschedule elective procedures. Following senior leader review, the Transfer Center is instructed to defer ICU admissions until staffing can meet the demand. Currently this has not been required. On daily multi-disciplinary rounds and when possible, ICU patients are downgraded and transferred to a lower level care unit. Case Management also identify patients who need repatriation, SNF/ Rehab level of care after discharge to expedite transfers. Nursing supervisors assess staffing frequently to anticipate staffing needs and escalate to respective manager, director and CNO/AOD. Measurable Goals: 100% compliance with staffing ratios in ICU. Denominator is the number of shifts, the numerator is the number of shifts we are in ratio. Monitoring Plan, Reporting Timeframes & Channels: The Staffing Ratios are reviewed at scheduled staffing calls (4 times daily and prn) and documented twice daily on the Nursing Supervisor's report. Daily Auditing is performed and reported to the daily COMPASS calls and monthly to QIC, MEC and BOT until 100% is achieved and sustained for 4 months then quarterly. We are currently at 100% compliance.	6/18/2021 7/20/2021 BOT

A 392	Intensive Care Unit (MNSICU), on 6/9/21 at 8:33 a.m., indicated there were nurse-to-patient ratios of one nurse to three patients on the NSICU: a. On 4/12/21, from 11 a.m. to 3 p.m., one bedside nurse had three assigned patients. b. On 5/4/21, from 3 p.m. to 7 p.m., two bedside nurses had three assigned patients each. c. On 5/5/21, from 7 a.m. to 11 a.m., three bedside nurses had three assigned patients each; and, from 11 a.m. to 7 p.m., two bedside nurses had three assigned patients each. d. On 5/9/21, from 3 p.m. to 7 p.m., one bedside nurse had three assigned patients; and, from 7 p.m. to 11 p.m., two nurses had three assigned patients each. e. On 5/10/21, from 7 a.m. to 11 a.m., three bedside nurses had three assigned patients each. During concurrent interview, the MNSICU acknowledged there were nurse-to-patient ratios of one nurse to three patients on the NSICU for those 5 days. Review of nursing staff assignment sheets with the ICU Director (DICU), on 6/9/2021 at 11:55 a.m., indicated the following periods when there were nurse-to-patient ratios of one nurse to three patients in the CVICU: a. On 5/5/2021, from 7 a.m. to 11:30 a.m., three bedside nurses had three assigned patients each. b. On 5/7/2021, from 7 a.m. to 11:30 a.m., one bedside nurse had three assigned patients. During concurrent interview with the ICU Director, she acknowledged the two time periods in May 2021 when there were nurse-to-patient ratios of one nurse to three patients on the CVICU. During an interview with the ICU Director, on 6/11/2021 at 11:20 a.m., she stated ICU patients were classified by acuity levels from 1 to 4. She stated Level 1 to level 3 patients could have nurse-to-patient ratios of 1:2, and Level 4 patients would have a nurse-to-patient ratio of 1:1.	A 392	A 392 2 Corrective Actions Taken: 6/16/2021 during the survey staffing reports reviewed to ascertain if each unit had a nurse leader scheduled for each shift. House Supervisors, charge nurses and CNCs instructed to ensure there is a nursing leader assigned for each shift. In the event staffing cannot be met, the issue is escalated to the manager, director, CNO/Admin on Call. Systemic Changes Implemented to Prevent Recurrence: Reviewed and revised Surge Plan to ensure resources are provided to coordinate patient care, monitor and coordinate unit operations, assess staffing needs for current census/ acuity, as well as the needs of the oncoming shift. (AOS) 100% House supervisors, Directors, Managers, CNCs / Charge Nurses trained on staffing, Surge Plan, and escalation processes. (AOS) Reviewed and revised Plan for Provision of Patient Care to clarify staffing for each unit to ensure resources are provided to coordinate patient care, monitor and coordinate unit operations, and assess staffing needs for current census/ acuity. (AOS) Reviewed core staffing for each unit and requested positions to fill vacancies to be able to staff to Core (number of nurses to staff for full census). Additional actions included: Set up mandatory 2-hour trainings for each CNCs on staffing to ensure understand and compliance with ensuring charge nurses/CNCs scheduled. Developed standard call log for all units. Developed attestation/ competency sign-off related to Code Green and Out of Ratio escalation, bed huddle process with script, and documentation of texts/calls to fill short staffed shifts. Measurable Goals: 100% of nursing units will have charge nurse/CNC available on each shift. Monitoring Plan, Reporting Timeframes & Channels:	6/16/2021 6/18/2021 6/27/2021 7/15/2021 7/20/2012 BOT 7/8/2021 7/7/2021 7/7/2021

A 392	Review of the Administrative Services Policy Manual, dated 2/24/2016, regarding the hospital's ICUs indicated, "Patients are assigned a nurse patient ratio of 1:1 or 1:2 depending on patient acuity, the California Nurse Staffing Ratio Regulation..." Review of the 2013 California Code of Regulations, Title 22, §70217(a)(1) indicated, "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..." Review of nursing staff assignment sheets with the NSICU Manager (MNSICU), on 6/11/2021 at 3:40 p.m., indicated the following time periods were without charge nurses present in the NSICU: 5/3/2021 from 3 p.m. to 7 p.m., 5/4/2021 from 3 p.m. to 11 p.m., 5/8/2021 from 3 p.m. to 7p.m., and 5/9/2021 from 3 p.m. to 11 p.m. During concurrent interview with the NSICU Manager, she acknowledged the four time periods in May 2021 that the NSICU lacked charge nurses and that there should have been charge nurses present. Review of nursing staff assignment sheets with the ICU Director, on 6/14/2021 at 9:37 a.m., indicated the following were time periods without charge nurses present in the CVICU: 5/4/2021 from 11 p.m . to 7 a.m. and 5/30/2021 from 7 a.m. to 11 a.m. During concurrent interview with the ICU Director, she acknowledged the two time periods in May 2021 that lacked charge nurses on the CVICU and that there should have been charge nurses present. a. Review of the emergency department staffing sheets, with the nurse manager emergency department (NMED), on 6/8/2021 at 2:30 p.m., indicated the following time periods were without charge nurses present: 5/26/2021 3 a.m. to 7 a.m. and 5/27/2021 from 3 a.m. to 7 a.m. During a concurrent interview with the NMED, she acknowledged the two time periods in May 2021 that lacked charge nurses in the ED.	A 392	Charge Nurse staffing is audited daily. Denominator is number of nursing units; numerator is number of charge nurses/ CNCs available for each unit. If a charge nurse/CNC is unavailable, an alternate nursing leader will be identified. Audits will be reported monthly to QIC, MEC and BOT until 100% is achieved and sustained for 4 months then quarterly. We are currently at 100% compliance. A 392 3 Corrective Actions: During the survey the patient's orders were reviewed and compared to the eMAR to ensure infusion titration accuracy. Systemic changes Implemented to Prevent Recurrence: All IV titratable drips are reviewed daily by charge nurses in the ICUs for physician order, parameters, rate on pump, guardrails on, and nurse following physician order(s). Daily audits of intensive care unit nursing documentation began on 6/14/21 and have continued since then on a daily basis. Physician orders are reviewed at the daily multidisciplinary rounds (which include pharmacists). Any duplicative orders will be identified and addressed with the provider. ICU Orders sets are being reviewed and revised. ICU nurses and clinical informatics to address all IV titratable medications to eliminate discrepancies and ensure accuracy. Measurable Goals: 100% IV titratable medications will be administered per physician orders. Denominator is the number of patients on IV titratable drips each day, numerator is the number of patients receiving titratable drips as prescribed. Monitoring Plan, Reporting Timeframes & Channels: All patients receiving IV titratable medications are monitored every day. The Critical Care Director or designee performs 20 audits (or 100% if there are less than 20 patients) daily of the patients who are on titratable medications in ICU. Audits will be present to Department of Critical Care, QIC, MEC and BOT until 100% is achieved	6/14/2021 6/14/2021 7/14/2021

A 392	b. Review of L&D's nursing staff assignment, for the evening shift, dated 6/12/2021, indicated there was no charge nurse assigned. During an interview, on 6/14/2021, at 11:30 a.m., RN L stated on 6/12/2021, four nurses were scheduled for the evening shift and there was no charge nurse in the unit. All efforts failed to find a charge nurse for the evening shift and the LD manger refused to come in to work as the charge nurse. RN M stated from 3:00 p.m. until 7:00 p.m. no nurse was available to function as a charge nurse in the L&D unit. Review of the Administrative Services Policy Manual, dated 2/24/2016, indicated, "Charge Nurses are scheduled each shift to coordinate the care of the patient population, monitor and coordinate unit operations, assess staffing needs for current census/acuity as well as the needs of the oncoming shift." 3. During a record review and concurrent interview with Manager of Neurosurgical Intensive Care Unit (MNSICU) on 6/10/21 at 1 p.m., the following were identified: a. Review of Daily Staffing Sheet NSICU, dated 5/5/21, from 7 a.m. to 7 p.m., indicated three patients, including Patient 8, were assigned to one registered nurse (RN). Review of Patient 8's Consultation Note, dated 4/30/21, indicated the "patient presented with left-sided weakness and altered mental status ...", "...on CT of the head, the patient was noted to have an acute hemorrhage [bleeding an escape of blood from a ruptured blood vessel]...", and "CT angiogram [a computed tomography technique used to visualize arterial and venous vessels] of the head and neck showed ...aneurysm [an excessive localized enlargement of an artery caused by a weakening of the artery wall]..." It indicated the plan was "Treatment of hypertensive emergency to systolic blood pressure [SBP, the force of the blood against artery walls when the heart beats] less than 140 mmHg [millimeters of mercury, a measurement of pressure)." Review of Patient 8's physician's order, dated 4/30/21, indicated Nicardipine (antihypertensive drug) to initiate at 5 milligrams per hour (mg/hr), titrate (dose changes based on patient response) up and down by 2.5 mg/hr every 5 minutes, maintain SBP less than 140 mmHg or Diastolic blood pressure (DBP, the pressure of	A 392	and sustained for 4 months then quarterly. We are currently at 100% compliance. A 392 4 Corrective Actions Taken: 6/14/2021 During the survey, assignment sheets were revised to clearly separate Peds versus PICU staffing and differentiate outpatient vs inpatient assignments. Systemic Changes Implemented to Prevent Recurrence: Good Samaritan Hospital understands that Pediatrics and the Pediatric Intensive Care Unit (PICU) are two distinct departments and that patients, charge nurses, and staff cannot be combined for any reason. The hospital and Nursing leaders are aware of this and have taken corrective action by creating separate staffing assignment sheets for Pediatrics and PICU so no patients or staff will be shared. In addition, we created separate inpatient and outpatient assignment sheets to ensure no nurse is providing care to inpatients and outpatients simultaneously. 100% of staff educated that any outpatient procedures (e.g., infusion, HRIF) need to have a dedicated outpatient nurse. Measurable Goals: Dir of Children's Services / designee perform daily audits of staffing assignment sheets for Peds, PICU, and outpatient services to ensure dedicated nursing staff are assigned for each unit and outpatient service. We have been 100% compliant with this since 6/14/21. Monitoring Plan, Reporting Timeframes & Channels: Continue daily audits in Peds, PICU and outpatient to confirm appropriate patient bed assignment and dedicated nursing staff for each area. Auditing results will be reported to the QIC, MEC and BOT until 100% is achieved and sustained for 4 months then quarterly. A 392 5 Corrective Actions Taken: 6/9/2021 During survey all suction set-ups in NICU changed. NICU RNs educated that all suction set-ups will be changed daily.	6/14/2021 6/14/2021 6/9/2021

A 392	the blood against artery walls while the heart is resting) less than 90 mmHg. The maximum rate was 15 mg/hr and the maintain goal was for 20 minutes, then titrate down to lowest rate that maintained the goal. If the drip was at zero rate, notify a provider immediately if the drip needed to be titrated up. Review of Patient 8's electronic medication administration record (eMAR), dated 5/5/21, indicated, at 10 a.m., Nicardipine was administered at 5 mg/hr and at 1:30 p.m., it was down to zero, instead of 2.5 mg/hr. There was no evidence a provider was notified. Review of Patient 8's blood pressure records and eMAR, dated 5/5/21, indicated the patient's blood pressure was 143/66 mmHg at 7:30 a.m., 155/80 mmHg at 8 a.m., 146/65 mmHg at 9 a.m., 152/64 mmHg at 9:16 a.m., 146/65 mmHg at 9:30 a.m., 148/67 mmHg at 9:45 a.m., and 156/65 at 10:15 a.m. There was no evidence Patient 8's Nicardipine was increased as ordered to maintain the patient's SBP less than 140 mmHg. During a concurrent interview, MNSICU stated Patient 8's Nicardipine was not administered and titrated as ordered. She stated the dose should be down by 2.5 mg/hr, the nurse should have notified a provider when the medication was discontinued, and Nicardipine should be increased when the patient SBP was checked more than 140 mmHg. b. Review of Daily Staffing Sheet NSICU, dated 5/4/21, from 3 p.m. to 7 p.m. and 5/5/21 from 7 a.m. to 7 p.m., indicated three patients, including Patient 12, were assigned to one RN. Review of Patient 12's physician order, dated 5/3/21, indicated Amiodaron e IV to infuse at 1 mg/min for 6 hours and 0.5 mg for 18 hours. It indicated the medication was started on 5/3/21 at 5:08 p.m. and stopped on 5/4/21 at 5:29 p.m. The order included to document the patient's heart rate (HR) and blood pressure (BP) per standard vital sign routine. Review of Patient 12's Blood Pressure, dated 5/4/21 indicated the BP was 169/72 mmHg at 5 a.m. and 128/61 mmHg at 7 p.m. There was no other BPs or HRs documented between 5 a.m. and 7 p.m. while the patient was on Amiodarone.	A 392	Systemic Changes Implemented to Prevent Recurrence: 6/9/2021 Created A NICU Suction Set-up Changing Plan 6/9/2021 Education plan started for Nursing Staff on Suction Set-up changes. 6/9/2021 NICU Charge Nurse responsible to audit Set-up to ensure compliance with changing and labeling plan. At 100% compliance currently. Measurable Goals: 100% of all Set-ups will be changed daily. Denominator is number of NICU patients; numerator is number Set-ups changed. Monitoring Plan, Reporting Timeframes & Channels: Set-up Audits performed daily. Audit results will be reported to the QIC, MEC and BOT monthly until 100% is achieved and sustained for 4 months then quarterly. A 392 6 Corrective Actions Taken: Worked with nursing supervisors to identify all sitter needs in the hospital. Deployed qualified staff to cover patient needs. Systemic Changes Implemented to Prevent Recurrence: A sitter float pool has been created to ensure sitter availability. Sitter positions have been posted to recruit and fill to meet needs. Nursing Supervisors assess sitter needs several times each shift and discuss in Charge nurse huddles. Any variance in sitter availability will be escalated immediately to ACNO/CNO. Measurable Goals: 100% of patients who need a sitter will have one. Dominator will be number total sitter patients, numerator will be number of total sitter staff. This is monitored daily. We are currently at 100% compliance. Monitoring Plan, Reporting Timeframes & Channels: Audits will be reported to Patient Safety Committee, QIC, MEC, BOT monthly until sustained results are 100% for 4 months then quarterly.	6/21/2021 7/14/2021

A 392	Review of Patient 12's other Amiodarone order, dated 5/5/21, indicated to infuse Amiodarone at 1mg/min. Review of Patient 12's eMAR indicated it was started on 5/5/21 at 3 p.m. and discontinued on 5/6/21 at 8:05 a.m. Review of Patient 12's Blood Pressure, dated 5/5/21, indicated the patient's BP was checked at 6 a.m. and the following documented BP was at 8:17 p.m. There were no documented BP and HR on 5/5/21, from 3 p.m. to 8 p.m. During a concurrent interview, MNSICU stated Patient 12's BP and HR should be monitored at least every 2 hours and there was no evidence the patient's BP and HR were monitored on 5/4/21, from 5 a.m. to 7 p.m. and on 5/5/21, from 3 p.m. to 8 p.m., while the patient was on Amiodarone. c. Review of Daily Staffing Sheet NSICU, dated 5/5/21 from 7 a.m. to 7 p.m., indicated three patients, including Patient 19, were assigned to one RN. Review of Patient 19's physician's order, dated 5/5/21, indicated Fentanyl IV 10 micrograms/hours (mcg/hr) to maintain pain scale (a pain scale measures pain on a scale of 0-10. 0 means no pain and 10 means the worst possible pain) less than 3. It indicated to titrate up and down by 10 mcg/hr every 60 minutes then, titrate to down to lowest rate that maintained the goal. Review of Patient 19's IV Drip Status indicated the patient's Fentanyl IV was initiated on 5/5/21 at 2:26 p.m., and discontinued on 5/10/21 at 9:50 p.m. Review of Patient 19's IV Drip Status and Pain assessment indicated on 5/5/21, there were no rate changes at 3 p.m. and 5 p.m. but there was no documented evidence the patient's pain was assessed to determine whether the pain scale met the goal and/or the titration was required. During a concurrent interview, MNSICU stated Patient 19's pain was not assessed every hour while the patient was on Fentanyl. d. Review of Daily Staffing Sheet NSICU, dated 5/9/21 from 3 p.m. to 7 p.m., indicated three patients, including Patient 20, were assigned to one RN.	A 392	A 392 7 Corrective Actions Taken: During the survey the Director of Women's Services reviewed the circumstances that led to the opening of the closed Antepartum unit to transfer one patient with only one nurse present on the unit. Systemic Changes Implemented to Prevent Recurrence: This event was discussed with L&D charge nurses to ensure understanding of the Antepartum staffing requirements which is a minimum of 2 nurses even if there is only one patient on the unit. Measurable Goals: There will be a minimum of 2 nurses on the Antepartum unit 100% of the time when patients are present. Monitoring Plan, Reporting Timeframes & Channels: There has been 100% compliance with this since 6/14/2021. Audit results will be reported to the QIC, MEC and BOT until 100% is achieved and sustained for 4 months, then reported quarterly. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH JUL 2 8 2021 L & C DIVISION SAN JOSE	6/14/2021 6/14/2021

A 392	Review of Patient 20's physician order, dated 5/8/21, indicated Acetaminophen 650 mg by oral as needed when the temperature was greater than 99°F. Review of Patient 20's eMAR, dated on 5/9/21 at 3:25 p.m., indicated Acetaminophen was administered for 5 of 10 pain on the head and neck and there was no documented evidence that the patient's pain was reassessed after the medication was administered. During a concurrent interview, MNSICU stated Patient 20's Acetaminophen was ordered for fever and the medication was administered for pain, an inappropriate indication and the nurse should have called the physician to get a new order for pain. She stated after administering a pain medication, the nurse should have reassessed the patient's pain to determine whether the intervention was effective. She stated medications should be administered as ordered. During a telephone interview on 6/13/21 at 11 a.m., registered nurse I (RN I) stated when she was assigned to three patients, she did not have enough time to document the necessary assessment for the IV titration. During a telephone interview on 6/13/21 at 1 p.m., registered nurse J (RN J) stated when she was assigned to three patients, she could not titrate the medication as ordered. She stated she titrated the patient's IV medication when she was able to assess the patient. She further stated she could miss documenting of the titration she performed because she did not have time to document during her shift. 4. During an interview on 6/11/21 at 10:35 p.m., the manager of pediatric department (MPD) stated the hospital has 4 licensed pediatric intensive care (PICU) beds, in Rooms 179, 180, 181, and 182, and 17 licensed pediatric (PED) beds. She stated one charge nurse is assigned to two units, PICU and PED units. During a record review and concurrent interview, on 6/14/21 at 11:06 a.m., with registered nurse L (RN L) and the manager of children services (MCS), the following were identified: Review of PICU ASSIGNMENT SHEET, dated 2/24/21, indicated at 2:30 p.m. two patients' acuity status, in Rooms 179 and 181, were	A 392		

A 392	changed from PICU to PED patients and they were remained in the same PICU beds, with the same nurse assigned. At the same time, an outpatient (a patient who receives medical treatment without being admitted to a hospital) was placed in Room 182, which was licensed for PICU bed, for infusion. A break nurse (break relief nurses are not assigned a patient load at the beginning of the shift, rather, they cover for nurses when the nurses are on their 15-minute morning break and hour-long lunch break) was assigned to the outpatient service. Review of PICU ASSIGNMENT SHEET, dated 2/25/21, from 3:30 p.m. to 8:40 p.m., a charge nurse was assigned to an outpatient's infusion service, in Room 181, which was licensed for PICU, while there was a PICU patient in another room. Review of PICU ASSIGNMENT SHEET, dated 4/6/21, indicated staffing for PICU and PED units were scheduled under one charge nurse assigned and two PED patients were placed in PICU, in Rooms 180 and 181. It indicated an outpatient was placed in Room 190, which was licensed for a PED bed, and an inpatient nurse provided outpatient infusion service, from 11:20 a.m. to 3:30 p.m. Review of PICU ASSIGNMENT SHEET, dated 4/7/21, indicated a charge nurse, who was assigned for both PICU and PED units, was assigned to an outpatient baby for a car seat challenge (a way used to identify babies that might be at higher risk for problems, such as trouble breathing while in a semi-reclined position) from 11 a.m. to 1:20 p.m. It indicated the charge nurse was also assigned to a new pediatric patient at 11:20 a.m. and she sent the patient to an operating room at 1:20 p.m. It indicated two RNs were sent to the neonate intensive care unit (NICU) on that shift to help them, while the PICU charge nurse provided care for outpatient service and to a pediatric patient. During a concurrent interview, MCS confirmed that the assignment of the car seat challenge was outpatient service and the care seat challenge required bed side monitoring. During a concurrent interview, RN L stated she was unsure the exact date but, at the end of February 2021, two units, PICU and PED units, were "combined" for staffing, due to the low census. One charge nurse from the PICU was	A 392		

A 392	assigned for both units, and PED patients were placed in PICU. Review of the 2013 California Code of Regulations, Title 22, §70491. Intensive Care Service definition indicated an intensive care service is a nursing unit in which there are specially trained nursing and supportive personnel and diagnostic, monitoring and therapeutic equipment necessary to provide specialized medical and nursing care to critically ill patients. Review of the 2013 California Code of Regulations, Title 22, §70535. Pediatric Service definition indicated Pediatric service means the observation, diagnosis and treatment (including preventive treatment) of children and their illnesses, injuries, diseases and disorders by appropriate staff, space, equipment and supplies. Review of the 2013 California Code of Regulations Title 22, §70537. Pediatric Service General Requirements indicated a pediatric nursing unit shall be provided if the hospital has eight or more licensed pediatric beds. Review of the 2013 California Code of Regulations Title 22, §70529. Outpatient Service Staff indicated the outpatient service shall have a person designated to direct and coordinate the service. Review of the 2013 California Code of Regulations Title 22, §70533. Outpatient Service Space indicated the number of examination and treatment rooms shall be adequate in relation to the volume and nature of work performed. 5. a. During an initial tour in the neonatal intensive care unit (NICU), with the manager of children services (MCS), on 6/7/21 at 10 a.m., in Room 1, including Beds 1-10, suction canisters (a temporary storage container that is used to collect body fluids or secretions from the patient from suctioning until it is disposed; suction canisters are usually attached to the wall of the patient's room or in close proximity to the patient's bed) were observed marked with "Exp. [expired] 6/6/21". During a concurrent interview, MCS stated a unit technician changes the suction canisters daily. On the previous day, no unit technician was working, and the suction canisters were not changed.	A 392		

A 392	b. During review of the NICU Breast milk Refrigerator log, dated 6/6/21, for a breast milk refrigerator in Room 1, indicated the temperatures were recorded at 39.7°F at 7:30 a.m. and 39.6°F at 7:45 p.m. Review of Sensor Alarm Report, dated 6/6/21 at 7:45 a.m., indicated the acceptable temperature ranged from 35°F to 39°F. It indicated the reason for the increased temperature was the opened door and the temperature was back within the range at 8:45 a.m. During a review of the NICU Breast milk Refrigerator log, dated 6/6/21, indicated the temperatures were recorded in red: 39.2°F at 2:45 p.m., 39.4°F at 3 p.m., 39.1°F at 3:15 p.m., 40.2°F at 3:30 p.m., 39.9°F at 3:45 p.m., 39.2°F at4 p.m., 39.3°F at4:15 p.m., 39.2°F at 4:30 p.m., 39.1°F at 4:45 p.m., 39.3°F at 5 p.m., 39.3°F at 5:15 p.m., 39.3°F at 5:30 p.m., and 39.3°F at 5:45 p.m. During an interview on 6/11/21 at 2 p.m., MCS stated a unit clerk was in charge to monitor the temperature of the breast milk refrigerator. On 6/6/21, the unit clerk did not check, and there was no evidence any actions were taken for the unacceptable temperatures, from 2:45 p.m. to 5:45 p.m. MCS stated she receives automatic alert e-mails regarding the unacceptable temperatures but she could not check the e-mails because it occurred on Sunday. 6. Review of Patient 3's History and Physical (the initial clinical evaluation and examination of the patient), dated 5/10/21, indicated the patient had a history of alcoholism (an addiction to the consumption of alcoholic liquor or the mental illness and compulsive behavior resulting from alcohol dependency), tachycardia (an abnormally rapid heart rate), and hypertension (a disease where blood flows through the arteries at higher than normal pressure). On 5/7/21, the patient visited the hospital's emergency department due to acute alcohol withdrawal (symptoms that may occur when a person who has been drinking too much alcohol on a regular basis suddenly stops drinking alcohol) and hypertensive urgency (an acute, severe elevation in blood pressure without signs or symptoms of end-organ damage). Review of Patient 3's physician order, dated 5/9/21 at 1:40 a.m., indicated the patient required a sitter.	A 392		

A 392	During an interview with the Director of Cardiovascular Unit (DCVU) on 6/10/21 at 1:10 p.m., she confirmed Patient 3 had a physician's order for a sitter. Upon reviewing the nursing staff assignment sheets and nurses' notes, the DCVU stated there was no documentation indicating a sitter was provided from the time it was ordered. A staff monitoring form, "Sitter/Suicide Precaution Observation Sheet", was also not completed. She acknowledged a sitter should have been provided as soon as possible after obtaining the order for patient safety, due to episodes of confusion and agitation. During a telephone interview with registered nurse G (RN G) on 6/11/21 at 1:10 p.m., she stated she was assigned to take care of Patient 3, on 5/9/21 from 7 a.m. to 3 p.m. RN G confirmed there was no sitter assigned to Patient 3 during her shift. Review of the hospital's policy, "Close Observation/Sitter Approval and Assessment for Continuation", dated 3/27/19, indicated the goal is to provide an added level of surveillance for patients deemed appropriate for consistent bedside monitoring. A sitter works under the supervision of the registered nurse to provide a physical presence to a patient or patients who display at risk behaviors. 7. Review of Patient 24's Antepartum Progress Notes, dated 5/18/21, indicated the patient was a 34-weeks pregnant woman with the diagnoses of placenta (a structure implanted into the wall of the uterus [the hollow, pear-shaped organ in a woman's pelvis where an unborn baby develops and grows] that supply the baby with oxygen and nutrients) previa (a serious condition that the placenta partially or totally covers the mother's cervix [the outlet for the uterus]) and vaginal bleeding. Review of L&D's nursing staff assignment sheet, dated 5/15/2021, with the director of woman's services (DWS), on 6/11/2021, at 10:30 a.m., indicated "[Room A] Antepartum closed, but pt [patient] in room. [name of a nurse] agreed to stay over." During an interview, on 6/8/2021, at 10:02 a.m., RN L stated Patient 24 had issues with noises and visitors in the L&D unit and the L&D manager decided to place the patient in Room A, in the antepartum unit, that was closed. She stated the patient was placed in Room A alone	A 392		

A 392	with a nurse in the closed unit and the patient was a high-risk pregnancy patient. During a concurrent interview, DWS acknowledged one nurse was assigned to Patient 24 in the closed antepartum unit. DWS stated there should have been two nurses assigned in the antepartum unit, even though there was only one patient, one back-up nurse, in case of an emergency situation. During an interview on 6/14/2021, at 2:15 p.m., the manager of L&D (MLD) stated she was aware Patient 24 was moved to the closed antepartum unit and one nurse was assigned. She stated there should have been two nurses assigned when a patient is admitted to the unit.	A 392		
A 397	PATIENT CARE ASSIGNMENTS CFR(s): 482.23(b)(5) A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. This STANDARD is not met as evidenced by: PATIENT CARE ASSIGNMENTS CFR(s): 482.23(b)(5) A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure a licensed nursing staff had proper training prior to providing care to a patient with an external ventricular drain (EVD, a temporary method that uses gravity to drain cerebrospinal fluid [CS, clear colorless bodily fluid found in the brain and spine] out of compartments in the brain, called ventricles, via a thin tube that exits out of the head into a bag). This failure had the potential to negatively affect the patients' health and safety. Findings: Review of Patient 25's Emergency Provider Report, dated 5/31/2021, indicated the patient visited the emergency department (ED) with a chief complaint of altered mental status (a change in cognition or level of consciousness) and clinical impressions of acute (sudden onset) thalamic (thalamus, one of the two oval-shaped	A 397	A 397 Title of Person Responsible for Corrective Action and Monitoring: CNO Corrective Actions Taken: Staff competencies pulled and reviewed for all ED RNs. Plan developed to ensure each RN had EVD training and competencies. Systemic Changes Implemented to Prevent Recurrence: Plan developed to ensure that each licensed nursing staff in the department will have proper training on the care of the patients with an external ventricular drain. (EVD) Plan includes each ED RN will be assigned 3 educational training videos using the hospital's computer-based training application. Following completion of the educational videos, each RN will take a written test via computer to validate successful understanding of learned materials. Each RN will also sign an attestation of receipt of information and knowledge of care of the patient with an external ventricular drain (EVD). Only RNs with competency will be assigned EVD patient care. Currently at 100% complete for those caring for patients. Measurable Goals: 100 % of ED RNs will demonstrate competence in caring for the patient with an external ventricular drain through return skills demonstration/signature validation of designated qualified educators/trainers. (AOS) This includes orientation of new team members. Denominator is the total number of ED nurses in the department; the numerator is number of ED	6/9/2021 7/16/2021 8/6/2021 6/9/2021

A 397	parts of the brain that control feeling and all the senses except for the sense of smell) bleed with a mass and hydrocephalus (a condition in which fluid accumulates in the brain). Review of Patient 25's Operative Report, dated 5/31/2021, indicated the placement of external ventricular drain (EVD) catheter through twist burr-hole technique was performed. Review of Patient 25's Emergency Notes, dated 5/31/2021, indicated "neurologist [a doctor who diagnosis and treat problems with the brain and nervous system] at bedside, ICU [Intensive Care Unit] nurse RN at bedside, EVD done on patient." During a telephone interview on 6/9/2021 at 11:10 a.m., registered nurse A (RN A) stated on 5/31/2021, she was assigned to Patient 25, and a neurologist and an ICU nurse were with Patient 25 for the EVD procedure. RN A stated after the procedure, the ICU nurse gave her instructions to monitor Patient 25 and left the ED. RN A stated she did not have training to take care of a patient with an EVD and was uncomfortable. During an interview and concurrent record review with the nurse manager in ED (NMED), on 6/10/2021 at 10:20 a.m., NMED stated RN A and the rest of the licensed nurses in the ED, did not have competency to take care of a patient who had an EVD. NMED stated for Patient 25, the ICU nurse should have stayed with the patient to monitor.	A 397	nurses who have successfully completed EVD training. Monitoring Plan, Reporting Timeframes & Channels: Monitoring and tracking will occur using generated electronic completion reports on a monthly basis to ensure compliance of 100% completion for each RN. Monitoring will be reported to QIC, MEC and BOT until 100% is achieved and sustained for 4 months then quarterly.	
A 398	SUPERVISION OF CONTRACT STAFF CFR(s): 482.23(b)(6) 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). This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure nursing staff followed the hospital's policies when: 1. In the neurosurgical intensive care unit (NSICU), registered nurses missed on-going	A 398	A 398 1 Title of Person Responsible for Corrective Action and Monitoring: CNO Corrective Actions Taken: Daily audits of intensive care unit nursing documentation began on 6/14/21 and have continued since then on a daily basis. The Critical Care Director or designee performs audits on ICU patients to evaluate the documentation of patient assessments and reassessments. Systemic Changes Implemented to Prevent Recurrence: We are utilizing a system-generated report that is run daily to evaluate the completion of nursing assessments and reassessments. Audits are then done concurrently with engagement of front-line staff. Coaching is provided to staff for any documentation gaps.	6/14/2021

A 398	assessments for 11 patients (Patients 9, 10, 11, 12, 14, 17, 18, 19, 20, 21, and 22), while one nurse was assigned to three patients. This failure had the potential of nursing staff not detecting patients' health complications or needs, and providing necessary treatment in the timely manner. Also, this failure can cause inaccurate and insufficient patients' information in their records. 2. In the post-operative care unit (PACU) a Broselow Pediatric cart (a pediatric resuscitation cart) had expired items. This failure had the potential of nursing staff using the expired items when they provide care to patients. 3. In the PACU and the antepartum unit (a unit designed for care for high-risk patients before delivery), nursing staff did not check the crash carts daily. This failure had the potential of not providing necessary supplies and equipment when an emergency occurs. Findings: 1.During record review and concurrent interview with the Manager of Neurosurgical Intensive Care Unit (NNSICU), on 6/9/21 at 8:33 a.m., the following were identified: a. Review of Daily Staffing Sheet NSICU, dated 5/5/21 from 7 a.m. to 7 p.m. indicated three patients (Patients 9,11, and 12) were assigned to one registered nurse (RN). Review of patient 9's Shift Assessment, dated 5/5/21, indicated the RN missed the patient's Assessment at 10 a.m., 12 p.m., 2 p.m., 4 p.m., and 6 p.m. Review of patient 11's Shift Assessment, dated 5/5/21, indicated the RN missed the patient's assessment at 8 a.m., 10 a.m. and 12 p.m. Review of patient 12's Shift Assessment, dated 5/5/21, indicated the RN missed the patient's assessment at 10 a.m., 12 p.m. and 4 p.m. b. Review of Daily Staffing Sheet NSICU, dated 5/5/21, from 7 a.m. to 7 p.m., indicated three patients (Patients 10, 13, and 19) were assigned to one RN. Review of Patient 19's Shift assessment, dated 5/5/21, indicated the RN missed the patient's assessment at 2 p.m., 4 p.m. and 6 p.m.	A 398	Measurable Goals: Nursing assessments will be completed and documented per hospital policy.100% of the time. Monitoring Plan, Reporting Timeframes & Channels: Audit results are currently at 100% and will be reported to the QIC, MEC and BOT until 100% is achieved and sustained for 4 months, then reported quarterly. A 398 2 a Immediate Actions Taken: During the survey expired items were removed and replaced. Systemic Changes to Prevent Recurrence: Centralized Equipment Distribution (CED) engaged to standardize the carts and start a cart exchange system. Every drawer has a list of items that it contains with the expiration dates. The drawer is sealed with breakaway plastic with the sheet of all items with the expiration dates. The expiration dates of all items are also put into a data-based application. This application has a barcode on each cart that when scanned will identify what items are expiring. Also, we have physically placed a label on the outside of every drawer that item that will be expiring with the soonest date. This is monitored daily and validated daily with nursing log sheets. There's now an extra cart for a Broselow cart exchange program. The Broselow cart exchange can be activated on i-mobile by any caregiver. CED will be checking all 6 Broselow carts to ensure carts are being check daily by nursing. If any cart has not been checked, nursing leadership is notified. If expired items are found, the drawer is replaced with a new seal. We are currently at 100% compliance. Measurable Goals: 100% there will be no expired items on the Broselow. Denominator is the number of Broselow carts, the numerator is the number of Broselow carts that have been checked and have no expired items. Monitoring Plans, Timeframes, & Reporting Channels:	6/11/2021 7/7/2021

A 398	c. Review of Daily Staffing Sheet NSICU, dated 5/9/21, from 7 p.m. to 11 p.m., indicated three patients (Patients 9, 19, and 20) were assigned to one RN. Review of Patient 9's Shift assessment, dated 5/9/21, indicated the RN missed the patient's assessment at 10 p.m. Review of Patient 20's Shift assessment, dated 5/9/21, indicated the RN missed the patient's assessment at 10 p.m. d. Review of Daily Staffing Sheet NSICU, dated 5/9/21, from 7 p.m. to 11 p.m., indicated three patients (Patients 10, 17, and 18) were assigned to one RN. Review of Patient 1O's Shift assessment, dated 5/9/21, indicated the RN missed the patient's assessment at 10 p.m. Review of Patient 17's Shift assessment, dated 5/9/21, indicated the RN missed the patient's assessment at 10 p.m. Review of Patient 18's Shift assessment, dated 5/9/21, indicated the RN missed the patient's assessment at 10 p.m. e. Review of Daily Staffing Sheet NSICU, dated 5/10/21, from 7 a.m. to 11 a.m., indicated three patients (Patients 9, 19, and 20) were assigned to one RN. Review of Patient 9's Shift assessment, dated 5/10/21, indicated the RN missed the patient's assessment at 10 a.m. Review of Patient 19's Shift assessment, dated 5/10/21, indicated the RN missed the patient's assessment at 10 a.m. Review of Patient 20's Shift assessment, dated 5/10/21, indicated the RN missed the patient's assessment at 10 a.m. f. Review of Daily Staffing Sheet NSICU, dated 5/10/21, from 7 a.m. to 11 a.m., indicated three patients (Patients 14, 21, and 22) were assigned to one RN. Review of Patient 14's Shift assessment, dated 5/10/21, indicated the RN missed the patient's assessment at 10 a.m.	A 398	Cart audit results will be presented to QIC, MEC and BOT monthly until 100% is achieved and sustained for 4 months then quarterly A 398 2 b Title of Person Responsible for Corrective Action and Monitoring: Chief Nursing Officer Corrective Actions Taken: On 6/16/21 OR Dir met with a Charge Nurse in PACU to discuss the expectation that a 24-hour inspection of crash carts will be performed and documented. On 6/16/21 Began daily auditing in all units with crash carts for 24-hour inspection documentation. On 6/27/21 Began a weekly audit by directors of documented inspection of Crash Cart Log completion Systemic Changes Implemented to Prevent Recurrence: On 7/15/21 a new process was established daily rounding implemented by CED to include crash cart inspection monitoring. Measurable Goals: 100% compliance with inspection of each adult crash cart 100% compliance with inspection of each pediatric crash cart Monitoring Plan, Reporting Timeframes & Channels: • CED will perform daily inspections of adult/pediatric crash cart log until 100% is achieved and sustained for 4 months • Directors will perform weekly audits of the daily inspection of the adult/pediatric crash cart log until 100% is achieved and sustained for 4 months • Compliance is reviewed daily to evaluate inspection of crash cart compliance and documentation • Results will be reported to the QIC, MEC and BOT monthly until 100% is achieved and sustained for 4 months then quarterly.	6/16/2021 6/16/2021 6/27/2021 7/15/2021

A 398	Review of Patient 21's Shift assessment, dated 5/10/21, indicated the RN missed the patient's assessment at 10 a.m. Review of Patient 22's Shift assessment, dated 5/10/21, indicated the RN missed the patient's assessment at 10 a.m. During a concurrent interview, MNSICU stated in the ICU, nurses perform the patient's full assessment at 8 a.m. then they should reassess patients every 2 hours and document their assessment. During a telephone interview on 6/13/21 at 11:00 a.m., registered nurse I (RN I) stated she was assigned to three patients and she did not have I time to perform assessment for three patients. She stated she had to quickly check other patients whether they were okay while she was busy with one patient. She stated she started documenting her assessment after her shift ended, because she did not have time to document her assessment during her shift. During a telephone interview on 6/13/21 at 1 p.m., registered nurse J (RN J) stated she was assigned to three patients and she missed either performing assessment or documenting her assessment. She stated she felt she did not have enough time to assess patients and she had to start documenting her assessment after she gave her shift report to the following shift nurse. She stated she did not have time to document patient's assessment during her shift. Review of the hospital's Intensive Care Units Standards of Care, dated 12/12/89 and revised 2/2019, indicated the RN will perform and document patient full assessment every shift with a selected focus system assessment every 2 hours. 2. a. On 6/7/2021 at 2:40 p.m., with the director of surgery (DOS), in the PACU, the Broselow Pediatric Cart was inspected and two expired items, Green IV (intravenous) Delivery Module with the expiration date of 4/30/2021 and Green intraosseous Module with the expiration date of 5/31/2021, were observed. During a concurrent interview, DOS confirmed the expired items. Review of Daily Crash Cart Checklist, dated January 2021, indicated the checklist remained blank on 1/11/2021, 1/13/2021, 1/19/2021, 1/20/2021, 1/24/2021, and 1/29/2021.	A 398		

A 398	Review of Daily Crash Cart Checklist, dated May 2021, indicated the checklist remained blank on 5/1/2021, 5/2/2021, 5/9/2021, and 5/16/2021. During an interview on 6/9/2021 at 8:20 a.m., DOS stated it was the responsibility of the registered nurses to check the pediatric crash cart daily and document. She confirmed that on those 10 days, there was no documented evidence nursing staff checked the crash cart daily as required. b. Review of the antepartum unit's Daily Crash Cart Checklist, dated April 2021, indicated the checklist remained blank on 4/1/2021 and 4/27/2021. Review of the antepartum unit's Daily Crash Cart Checklist, dated May 2021, indicated the checklist remained blank on 5/5/2021, 5/6/2021, 5/11/2021, 5/12/2021, 5/15/2021, 5/23/2021, and 5/28/2021. During an interview with the director of women's services (DW S), on 6/11/2021 at 2:30 p.m., she confirmed there was no documented evidence nursing staff checked the crash cart on those days. Review of the hospital's policy, "Resuscitation of an Adult/Pediatric Patient (Code Blue)", dated 5/27/2020, indicated, "Emergency Cart Management: Inspection and Stocking (Crash Carts and Broselow carts)...The Charge Nurse or designate is responsible to insure the routine emergency cart inspections are completed per policy. Once in 24 hours (daily inspection), designated personnel will inspect the emergency cart for intactness of the lock, inspect the presence of necessary supplies and equipment on open areas of cart. Signing, initialing or documenting...on the emergency cart checking record implies that all emergency supplies are present, that the emergency cart is sealed by a lock, and that equipment checks have been performed."	A 398		

A 405	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure nursing staff administered medications as ordered for four patients (Patients 8, 12, 19, and 20), who received care in the intensive care unit (a unit where seriously ill patients receive specialized care), when: 1. Patient 8's Nicardipine (antihypertensive drug) was not administered and titrated as ordered. 2. There was no evidence Patient 12's blood pressure (BP) and heart rate (HR) were monitored constantly while the patient was on intravenous (IV) Amiodarone (a medication to treat irregular heartbeat). 3. Patient 19's Fentanyl (a very strong narcotic pain medication) IV drip was not titrated as ordered and relevant pain assessment, to titrate the medication, was missing. 4. Patient 20's Tylenol (a pain medication) was administered with an inappropriate indication and there was no evidence the patient's pain was reassessed. These failures had the potential to cause harm to the patients receiving inaccurate medications.	A 405	A 405 1 Title of Person Responsible for Corrective Action and Monitoring: CNO Corrective Actions: During the survey the patient's orders were reviewed and compared to the eMAR to ensure infusion titration accuracy. Systemic changes Implemented to Prevent Recurrence: All IV titratable drips are reviewed daily by charge nurses in the ICUs for physician order, parameters, rate on pump, guardrails on, and nurse following physician order(s), Physician orders are reviewed at the daily multidisciplinary rounds (which include pharmacists). Any duplicative orders will be identified and provider notified to correct or discontinue. ICU Orders sets are being reviewed and revised. ICU nurses and clinical informatics to address all IV titratable medications to eliminate discrepancies and ensure accuracy. Measurable Goals: 100% IV titratable medications will be administered per physician orders. Denominator is the number of patients on IV titratable drips each day, numerator is the number of patients receiving titratable drips as prescribed. Monitoring Plan, Reporting Timeframes & Channels: All patients receiving IV titratable medications are monitored every day. Audits will be presented to Department of Critical Care, QIC, MEC and BOT. monthly until 100% is achieved and sustained for 4 months then quarterly. We are currently at 100% compliance. A 405 2 Title of Person Responsible for Corrective Action and Monitoring: CNO Corrective Actions : ICU Leadership reviewed incident and medical record to identify documentation deficiency.	6/14/2021 6/14/2021 7/14/2021

A 405	Findings: During a record review and concurrent interview, with the Manager of Neurosurgical Intensive Care Unit (MNSICU), on 6/10/21 at 1 p.m., the following were identified: 1. Review of Patient 8's Consultation Note, dated 4/30/21, indicated the "patient presented with left-sided weakness and altered mental status...", "on CT of the head, the patient was noted to have an acute hemorrhage [bleeding an escape of blood from a ruptured blood vessel]...", and "CT angiogram [a computed tomography technique used to visualize arterial and venous vessels] of the head and neck showed...aneurysm [an excessive localized enlargement of an artery caused by a weakening of the artery wall]..." It indicated the plan was "Treatment of hypertensive emergency to systolic blood pressure [SBP, the force of the blood against artery walls when the heart beats] less than 140 mmHg [millimeters of mercury, a measurement of pressure]." Review of Patient 8's physician's order, dated 4/30/21, indicated Nicardipine (antihypertensive drug) to initiate at 5 milligrams per hour (mg/hr), titrate (dose changes based on patient response) up and down by 2.5 mg/hr every 5 minutes, maintain SBP less than 140 mmHg or diastolic blood pressure (DBP, the pressure of the blood against artery walls while the heart is resting) less than 90 mmHg. The maximum rate was 15 mg/hr and the maintain goal was for 20 minutes, then titrate down to lowest rate that maintained the goal. If the drip was at zero rate, notify a provider immediately if the drip needed to be titrated up. Review of Patient 8's electronic medication administration record (eMAR), dated 5/5/21, indicated at 10 a.m., Nicardipine was administered at 5 mg/hr and at 1:30 p.m., the rate was down to zero, instead of 2.5 mg/hr. There was no evidence a provider was notified. Review of Patient 8's blood pressure records and eMAR, dated 5/5/21, indicated, the patient's blood pressure was 143/66 mmHg at 7:30 a.m., 155/80 mmHg at 8 a.m., 146/65 mmHg at 9 a.m., 152/64 mmHg at 9:16 a.m., 146/65 mmHg at 9:30 a.m., 148/67 mmHg at 9:45 a.m., and 156/65 at 10:15	A 405	Follow up with ICU staff during shift huddles and through auditing to remind staff to ensure vital signs are time-stamped and downloaded into the critical care flow sheet that is imbedded in the eMAR. Systemic Changes Implemented to Prevent Recurrence: Immediate actions: Audits were conducted ICU patients who were on IV drip audits were implemented 6/22/21 to validate vital signs are present on the eMAR. Measurable Goal 100% compliance with documenting vital signs in the eMAR. Denominator is the number of patients in ICU who are on IV drips; numerator the number of patients who have vital signs documented. Monitoring Plan, Reporting Timeframes / Channels: Audit Results will be presented to QIC, MEC and BOT monthly until 100% is achieved and sustained for 4 months then quarterly A 405 (2) 3 Title of Person Responsible for Corrective Action and Monitoring: CNO Corrective Actions : ICU Leadership reviewed incident and medical record to identify titration and documentation deficiency. Follow up with ICU staff during shift huddles and through auditing to remind staff to ensure pain medications are administered based on patient's pain assessment in accordance with physician orders. Systemic Changes Implemented to Prevent Recurrence: Immediate actions: Audits were conducted on ICU patients who were on IV pain meds. Audits were implemented 6.22.21 to validate pain assessments and appropriate IV pain med titration. Measurable Goal 100% compliance with documenting pain assessments are documented along with IV pain medication administration. Denominator is the number of patients in ICU who are on IV pain drips; numerator the number of patients who have pain assessments documented that are consistent with physician orders.	6/22/2021 6/22/2021

A 405	a.m. There was no evidence Patient 8's Nicardipine was increased as ordered to maintain the patient's SBP less than 140 mmHg. During a concurrent interview, MNSICU stated Patient 8's Nicardipine was not administered and titrated as ordered. She stated the dose should be down by 2.5 mg/hr, the nurse should have notified a provider when the medication was discontinued, and Nicardipine should be increased when the patient SBP was checked more than 140 mmHg. 2. Review of Patient 12's physician order, dated 5/3/21, indicated Amiodarone IV to infuse at 1 mg/min for 6 hours and 0.5 mg for 18 hours. The IV drip was started on 5/3/21 at 5:08 p.m. and stopped at 5/4/21 at 5:29 p.m. The order included to document the patient's HR and BP per standard vital sign routine. Review of Patient 12's Blood Pressure, dated 5/4/21 indicated, the BP was 169/72 mmHg at 5 a.m. and 128/61 mmHg at 7 p.m. There was no other BPs or HRs documented, on 5/4/21 from 5 a.m. to 7 p.m., while the patient was on Amiodarone. Review of Patient 12's another Amiodarone order, dated 5/5/21, indicated to infuse Amiodarone at 1mg/min. Review of Patient 12's eMAR indicated, the IV drip was started on 5/5/21 at 3 p.m. and discontinued on 5/6/21 at 8:05 a.m. Review of Patient 12's Blood Pressure, dated 5/5/21, indicated the patient's BP was checked at 6 a.m. and the following documented BP was at 8:17 p.m. There were no documented BP and HR on 5/5/21 from 3 p.m. to 8 p.m. During a concurrent interview, MNSICU stated Patient 12's BP and HR should be monitored at least every 2 hours and there was no evidence the patient's BP and HR were monitored on 5/4/21 from 5 a.m. to 7 p.m. and on 5/5/21 from 3 p.m. to 8 p.m., while the patient was on Amiodarone. 3. Review of Patient 19's physician's order, dated 5/5/21, indicated Fentanyl IV 10 micrograms/hours (mcg/hr) to maintain pain scale (a pain scale measures pain on a scale of 0-10. O means no pain and 10 means the worst possible pain) less than 3. It indicated to titrate	A 405	Monitoring Plan, Reporting Timeframes / Channels: Audit Results will be presented to QIC, MEC and BOT monthly until 100% is achieved and sustained for 4 months then quarterly. 405 4 Title of Person Responsible for Corrective Action and Monitoring: CNO Corrective Actions Taken: Medical record review with involved ICU nurse. It was confirmed that Tylenol was ordered for fever but given for pain. Systemic Changes Implemented to Prevent Recurrence: Audits to be conducted to assess whether Tylenol is administered as ordered. Measurable Goal 100% of Tylenol administered per MD orders Monitoring Plan, Reporting Timeframes / Channels: Audit Results will be presented to QIC, MEC and BOT monthly until 100% is achieved and sustained for 4 months then quarterly. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH JUL 2 8 2021 L & C DIVISION SAN JOSE	6/14/2021 7/12/2021

A 405	up and down by 10 mcg/hr every 60 minutes then, titrate to down to lowest rate that maintained the goal. Review of Patient 19's IV Drip Status indicated the patient's Fentanyl IV was initiated on 5/5/21 at 2:26 p.m. and discontinued on 5/10/21 at 9:50 p.m. Review of Patient 19's IV Drip Status and Pain assessment indicated, on 5/5/21, there were no rate changes at 3 p.m., 5 p.m. 9:20 p.m. 9:30 p.m. but there was no documented evidence the patient's pain was assessed to determine whether the pain scale met the goal and/or the titration was required. It also indicated the patient's pain was not assessed from 5/5/21 at 10 p.m. to 5/6/21 at 8 a.m. while the patient was on Fentanyl. During a concurrent interview, MNSICU stated Patient 19's pain was not assessed every hour while the patient was on Fentanyl. 4. Review of Patient 20's physician order, dated 5/8/21, indicated Acetaminophen 650 mg by oral as needed when the temperature was greater than 99°F. Review of Patient 20's eMAR, dated on 5/9/21 at 3:25 p.m., indicated Acetaminophen was administered for 5 of 10 pain on the head and neck and there was no documented evidence that the patient's pain was reassessed after the medication was administered. During a concurrent interview, MNSICU stated Patient 20's Acetaminophen was ordered for fever, the medication was administered for pain, an inappropriate indication, and the nurse should have called the physician to get a new order for pain. She stated after administering a pain medication, the nurse should have reassessed the patient's pain to determine whether the intervention was effective. She stated medications should be administered as ordered. Review of the hospital's policy, "Administration of Medication by Nursing", dated 1/97 and revised 6/20, indicated to document intravenous fluids on the eMAR and rate changes for titrated infusions will also be documented in eMAR as appropriate with completion of any required queries. A patient's response to a medication is assessed and documented in the medical record.	A 405		