STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054087	A. BUILDING _____ B. WING _____	08/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA VISTA HOSPITAL, INC	8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS	A 000		

The following reflects the findings of the California Department of Public Health during a full medicare survey following a complaint validation survey.

During the survey, the hospital was determined to meet the criteria of a dedicated emergency department (DED) per definitions at 42 CFR §489.24(b).

Representing the Department:

Alina Davis RN, 17334
Deidre Sakauye RN, 20435
Denise Howell, RN, 17071
Letitia Creighton, RN, 16501
Esther Cistone MD, 22710
John Christensen, Pharmacist, 15338
Francia Trout, Medical Records, 11389
Dagma Bender-Porter, RD, 17065

The number of certified beds-72
The sample size-66 (35 inpatients, 30 walk-in scheduled and unscheduled Admission and Referrals Department outpatients, 1 outpatient/other)
The initial census-62 .

Abbreviations:
A&R = Assessment and Referrals
cc = cubic centimeters
CT=Computed Tomography (a diagnostic test)
CEO=Chief Executive Officer
DSD = Director of Staff Development
EMC= emergency medical condition
EMTALA = Emergency Medical Treatment and Active Labor Act
ER = Emergency Room

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

CEO | 10/6/08

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

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A 000	Continued From page 1 GACH = General Acute Care Hospital ICP-Infection Control Practitioner LCSW = Licensed Clinical Social Worker I&O, I/O = Intake ans Output LN=Licensed Nurse MAR= Medication Administration Record MD = Medical Doctor MFT = Marriage and Family Therapist MHT = Mental Health Technician MRI=Magnetic Resonance Imaging (a diagnostic test) MSE = Medical Screening Examination MSW = Masters of Social Worker P&P = Policy and Procedure QMP = Qualified Medical Person or Personnel RD = Registered Dietitcian RN = Registered Nurse SVH/SV = Sierra Vista Hospital STAT=immediate 5150 hold=74 hours involuntary hold QAPI=Quality Assessment Performance Improvement EMTALA/OBRA/COBRA = prior reference for EMTALA	A 000		
A 023	482.11(c) LICENSURE OF PERSONNEL The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws. This STANDARD is not met as evidenced by: Based on staff interviews, medical record and document reviews, the hospital failed to assure that personnel met applicable standards required by State or local laws. The hospital failed to ensure that RNs performed MSEs in A&R based on standarized procedures.	A 023	**482.11(c.) LICENSURE OF PERSONNEL** Sierra Vista Hospital now ensures that it provides a Medical Screening Exam (MSE) by a Qualified Medical Personnel (QMP) for anyone who presents for an unscheduled visit. 1. ***900.40 Standardized Procedure for Qualified Medical Personnel-Registered Nurses*** was created to define the standardized procedures for QMP in accordance with the Title 22,	9/30/08

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A 023	Continued From page 2 Findings: The hospital Medical Staff Rules and Regulations (approved on 3/19/08) indicated in Section 21: "In addition to physicians, the following classes of practitioners are granted authority, within the scope of the clinical privileges or prerogatives for which they have been approved, to conduct medical screening examinations ... : RN's with specified QMP medical screening training." California Business and Professions Code, Chapter 6. Nursing, Article 2. Scope of Regulation, Section 2725, Legislative intent, Practice of Nursing, (c) "Standardized procedures," as used in this section, means: (1) Policies and protocols developed by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code through collaboration among administrators and health professionals including physicians and nurses. The policies and protocols shall be subject to any guidelines for standardized procedures that the Division of Licensing of the Medical Board of California and the Board of Registered Nursing may jointly promulgate (make known to the public; disseminate; proclaim; cause to come forth). If promulgated, the guidelines shall be administered by the Board of Registered Nursing (BRN). California Code of Regulations, Title 16 Division 14. Board of Registered Nursing Article 7. Standardized Procedure Guidelines. Section 1471. Definitions For purposes of this article: (a) "Standardized procedure functions" means those functions specified in Business and	A 023	the Nurse Practice Act, and the BRN Guidelines for Standardized Procedures; final approval 9/30/2008. 2. ***900.41 Interdisciplinary Practices Committee*** was approved to provide oversight for standardized procedure functions. 9/30/08 3. The competency process for the QMP in accordance with Standardized Procedures is in place. 10/1/08 4. The hospital will undertake a comprehensive evaluation of the patient population served and has identified potential emergency care scenarios, for which assessment, policies, procedures, training and competencies have been developed to enable it to provide safe and adequate initial treatment of an emergency. 10/31/08 Individual(s) responsible: ◆ Medical Director ◆ COO ◆ Director of Nursing ◆ Regulatory Compliance Officer **How Monitored:** ◆ Method of monitoring emergency procedures will include monthly collection of performance data on quality indicators including	

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A 023	Continued From page 3 Professions Code Section 2725(c) and (d) which are to be performed according to "standardized procedures"; Section 1472. Standardized Procedure Functions An organized health care system must develop standardized procedures before permitting registered nurses to perform standardized procedure functions. A registered nurse may perform standardized procedure functions only under the conditions specified in a health care system's standardized procedures; and must provide the system with satisfactory evidence that the nurse meets its experience, training, and/or education requirements to perform such functions. Section 1474. Standardized Procedure Guidelines Following are the standardized procedure guidelines jointly promulgated by the Medical Board of California and by the Board of Registered Nursing: (a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision thereof. (b) Each standardized procedure shall: (1) Be in writing, dated and signed by the organized health care system personnel authorized to approve it. (2) Specify which standardized procedure functions registered nurses may perform and under what circumstances. (3) State any specific requirements which are to be followed by registered nurses in performing particular standardized procedure functions. (4) Specify any experience, training, and/or education requirements for performance of standardized procedure functions. (5) Establish a method for initial and continuing evaluation of the competence of those registered	A 023	documentation on logs, completeness of documentation for all assessments, and appropriateness of dispositions. Data will be collected monthly and reported quarterly. ♦ The Director of Performance Improvement (DPI) will aggregate, analyze and trend the data and present to the Hospital Quality Council, Medical Staff, Medical Executive Committee and Board of Trustees on a quarterly basis. ♦ A sample of medical records reflecting initial treatment of persons who are determined to have an emergency condition are now monitored weekly by the Medical Director, members of the Medical Staff , Director of Nursing and Director of Assessment & Referral. Deficiencies are immediately addressed and results are tracked, trended, analyzed and used to improve clinical processes. Evidence: ♦ Sample of Audit tool ♦ Minutes of Medical Policy Committee 9/24/08, and MEC, and Board of Trustees 9/30/08.	

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A 023	Continued From page 4 nurses authorized to perform standardized procedure functions. (6) Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions. (7) Specify the scope of supervision required for performance of standardized procedure functions, for example, immediate supervision by a physician. (8) Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition. (9) State the limitations on settings, if any, in which standardized procedure functions may be performed. (10) Specify patient record keeping requirements. (11) Provide for a method of periodic review of the standardized procedures. On 7/22/08 at 1 p.m. the Director of the Outpatient Services presented a 2-page P&P (Policy 900.20) "Medical Screening Exam" as a standardized procedure used by the RN's when performing MSEs. The P&P defined a medical screening examination as, "the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether an emergency medical condition does or does not exist. The Medical Screen shall be completed by Qualified Medical Personnel following when an individual presents to the facility for assessment." The P&P contained a list of life-threatening and potential Medical Emergencies, a list of acute psychiatric emergencies and pain scale and indicated to document any medical treatment provided to stabilize the condition for patients presenting with EMC. The Director of the Outpatient Services presented the P&P, entitled	A 023		

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A 023	Continued From page 5 "Medical Screening Examination," as fulfilling the standardized procedure for the QMP RNs, yet the P&P did not contain the eleven elements of a standardized procedure described by State law. On 7/22/08 at 1 p.m. the Director of the Outpatient Services, stated that RNs with EMTALA training, which was provided by her at the facility, performed MSEs for all walk-in patients presenting to the facility potentially seeking treatment for emergency medical conditions in the A&R department. The Director of the Outpatient Services stated that she evaluated RN's competencies for MSE by administering a 2-page test and evaluated the results by using a test key (containing the answers to the questions). The test contained questions about medical presentations and what action the QMP should take (call 911, call MD, send patient home) but did not reflect the elements of a medical screening exam, the focus on identified complaints and symptoms, how an emergency medical condition was defined, how ongoing monitoring was part of a medical screening exam, or the capabilities of the hospital to respond to emergency medical conditions identified as a result of a medical screening exam. In short, the QMP test did not reflect competence of a trained QMP RN. The Director of the Outpatient Services confirmed that she was not a QMP. In an interview with the Director of Outpatient Services conducted on 7/22/08 at 1 p.m, she stated the QMP RN's did not operate under standardized procedures to perform MSE's.	A 023		
A 043	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the	A 043		

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A 043	Continued From page 6 hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: Based on observation, staff interviews, medical record and document reviews, the hospital failed to have an effective governing body legally responsible for the conduct of the hospital as an institution as evidenced by the following failures: A. To ensure that the medical staff enforced its bylaws, rules and policies relating to Qualified Medical Personnel who perform medical screening exams, infection control oversight, quality assessment and performance improvement activities oversight, emergency services and compliance with EMTALA requirements, credentialing and privileging providers of radiology services and off-campus consultation services, and timely completion of physician orders. [cross reference A 0049, A 0338, A 0353, A 1104, A 1112] B. To ensure that the medical staff was accountable to the governing body for the quality of care for hospital patients in all locations. [cross reference A 0049, A 0338, and A 747] C. To ensure that contracted services were performed in a safe and effective manner and that contractors provided services that permit the hospital to comply with all Conditions of Participation. [cross reference A 0084] D. To ensure compliance with CFR 482.55 for	A 043	**482.12 GOVERNING BODY** Sierra Vista Hospital ensures that the medical staff bylaws, rules and policies related to Qualified Medical Personnel who perform medical screening exams are enforced. In July, 2008, the following actions were initiated. 1. Development of a standardized procedure for the performance of Medical Screening Exams — 7/30/08 2. Training of RNs in accordance with the standardized procedure; training conducted by physicians and QMP RN Trainer — 9/24/08 3. Monitoring of competency by a physician or a qualified QMP RN via proctoring in the performance of Medical Screening Exams — 8/1/08 and ongoing 4. Oversight of RN performance of Medical Screening Exams by SVH designated members of the SVH medical staff — 8/1/08 and ongoing 5. Approval of the standardized procedure and creation of an Interdisciplinary Practices Committee by the Medical Policy Committee of the SVH medical staff on 9/24/08. — 9/30/08	

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	Continued From page 7		6. Approval of the standardized procedure and creation of an Interdisciplinary Practices Committee by the MEC and Board of Trustees on 9/30/08. Implementation of these corrective actions was completed on 9/30/08. Individual(s) accountable: ◆ Medical Director ◆ President of the Medical Staff ◆ DON ◆ Regulatory Compliance Officer **How Monitored:** ◆ Method of monitoring is via 100% audit of MSE documentation for completeness, accuracy, and adherence to the standardized procedure. Variances are addressed via remedial education. ◆ Frequency of monitoring is daily ◆ Oversight of findings / compliance data or other evidence by the Interdisciplinary Practices Committee, with reports to the MEC and Board of Trustees. ◆ Medical staff approval via the Medical Policy Committee on 9/24/08, and MEC 9/30/08 ◆ Copy of SVH policy 900.40 and	9/30/08

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	Continued From page 7A		900.41 attached. Sierra Vista Hospital provides oversight for the Infection Control Program through the medical staff. The Governing Body, through the Medical Executive Committee, initiated the following actions on 8/11/2008: ◆ An evaluation of the Infection Control Program was completed by an external Best Practices expert on 9/8/-08 through 9/12/08. ◆ Based on the evaluation, the Medical Staff comprehensively revised the Infection Control Program Policies and Procedures; these were approved by the Medical Staff on 9/16/08 and 9/17/08. ◆ Infection Control data were presented to the medical staff on 9/16/08 and 9/17/08 consistent with requirements in article 8.3(b) of the Board of Trustees Bylaws and Section 11.4.9 (a) through (c.) of the Medical staff Bylaws.	9/30/08 9/30/08 and ongoing

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	Continued From page 7B		◆ The report of the Annual evaluation was made to the medical staff on 9/30/08.	9/30/08
			◆ The Governing Body now requires Medical Staff reporting of Infection Control as part of its standing agenda.	10/1/08
			Individual(s) responsible: ◆ Regulatory Compliance Officer ◆ Medical Director ◆ Infection Preventionist	
			How Monitored: ◆ Method of monitoring Infection Control will include monthly collection of performance data on quality indicators including TB screening of employees, flu vaccination program for inpatients and employees, and Hepatitis C program effectiveness and quarterly reports to the SVH medical staff and Board of Trustees. ◆ Data will be collected monthly and reported quarterly. Oversight will be provided by the medical staff committee(s) responsible for infection control, performance improvement, MEC and the Board of Trustees. ◆ Reports required under	

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	Continued From page 70		California SB739 Hospital Infectious Disease Program will be prepared and submitted to the medical staff committees responsible for infection control and QAPI, to MEC and the Board of Trustees as well as to CADPH beginning October 2008. ♦ Revised Infection Control Manual approved by medical staff on 9/16/08 and 9/17/08. Annual Infection Control Program evaluation presented to medical staff on 9/30/08. The Sierra Vista Hospital Governing Board now ensures that services performed under transfer agreements with local acute care hospitals are safe, effective, evaluated for quality of the services. On 10/1/2008, the following actions were initiated: 1. A contractor evaluation form has been adopted for consistent and systematic data collection. 10/1/08 2. Quality Indicators have been derived from the form and a tracking and trending process established. 10/1/08 3. A contractor evaluation form has been adopted. 10/1/08 4. An oversight committee was created by the SVH Medical Director to review quality of care and performance data on all	

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	Continued From page 7D		patient care contractors. Members include SVH medical staff, the SVH Regulatory Compliance Officer, and vendor representatives. This committee reports to the Medical staff and MEC and through them to the Board of Trustees no less than annually.	
			5. A Transfer Agreement amendment was finalized on 9/25/2008 for both local hospitals contracted with the Hospital. • This Amendment has been reviewed by Methodist Hospital and Kaiser Foundation Hospital South legal departments and has been approved.	9/25/08
			6. A new Service Agreement was written for a local outpatient diagnostic clinical radiology service. This new agreement specifies roles and responsibilities of each organization for the care and supervision of the patient from the time of the hospital physician order to the return of the patient. This document also defines the quality oversight of this service.	10/3/08
			7. Radiologists will maintain Hospital medical staff privileges as consultant members.	10/3/08

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	Continued From page 7E		8. A second agreement for on-site radiology services is in process.	10/6/08
			Individual(s) responsible: ◆ CEO ◆ Medical Director ◆ President of the Medical Staff ◆ Regulatory Compliance Officer	
			How Monitored: ◆ Patient Care Contracts are reviewed for performance quality by the MEC and Board of Trustees annually. ◆ The Director of PI is responsible for collecting, analyzing & reporting monitoring evidence ◆ Reports will be made to the Medical Staff, MEC and through them to the Board of Trustees no less than annually	
			Sierra Vista Hospital now ensures compliance with the requirements of CFR 482.55, the condition of emergency services.	
			1. The facility now ensures that the services available to inpatient units are integrated into the Assessment and Referral area such that patients presenting with emergency conditions receive stabilizing initial treatment with the capability of the hospital and equivalent to	9/1/08

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	Continued From page 7F		treatments offered to inpatients. ◆ All patients presenting for an unscheduled assessment who are deemed to have an emergency medical condition (EMC) will receive stabilizing treatment within the capability of the hospital. ◆ Clinical Services Policies, **900.18** *Emergency Screening and Initial Assessment*, **900.20** *Medical Screening Exam* and **900.22** *Emergency Care* were amended to include clear guidelines for the role(s) and function(s) of the physician and RN QMP to oversee and provide supervision and stabilization based on assessed patient needs. ◆ Sierra Vista Hospital now ensures that it does not solely rely on 911 emergency services, and does provide initial appraisal and stabilizing treatment within the hospital's capability and capacity. 2. Sierra Vista Hospital now ensures timely and effective communication between the hospital and off-campus emergency providers authorized	10/1/08

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	054087	A. BUILDING _____ B. WING _____	08/01/2008

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SIERRA VISTA HOSPITAL, INC	8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823

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	Continued From page 16		to provide care under a transfer agreement. ◆ The hospital's transfer agreement has been amended and now requires compliance by contracted hospitals. Transfers are audited to assure documentation is received.	
			3. Sierra Vista Hospital now ensures that emergency policies and procedures are followed by hospital staff. ◆ RN's working in the Assessment and Referral department (A & R) were educated regarding the appropriate management of patients presenting with an EMC as defined in **Policies 1000.13** *Major Medical Emergency Treatment* and **900.22** the *Emergency Care*. ◆ Training included appropriate utilization of emergency equipment and calling a Code Blue.	9/30/08
			4. Sierra Vista Hospital now ensures that all emergency care is supervised by a qualified member of the medical staff.	8/1/08 and onogoing
			5. Sierra Vista Hospital now ensures	9/30/08

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	Continued From page 74		that RNs providing medical screening exams (MSE) and stabilizing treatment to patients with emergency medical conditions (EMC) are qualified and functioned in accordance with state laws. Individual(s) responsible: ◆ Medical Director ◆ Director of Nursing ◆ Director of Assessment and Referral ◆ COO ◆ Regulatory Compliance Officer **How Monitored:** ◆ The A & R QI Indicator Tool, which evaluates the completion of the Medical Screen components, stabilization documentation and authorization for transfer form (if applicable) will be monitored on a weekly basis by the Director of A & R. Identified trends will be corrected through staff education and staff disciplinary procedures. ◆ The Director of Assessment and Referral maintains a copy of all *Authorization for Transfer* forms and reviews 100% of the forms for completeness to assure documentation of care and transfers are accurately	

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	Continued From page 11		completed. ♦ Management of emergency care will be monitored via daily review by the A&R Director of the incident report log and 100% of face to face assessments for adequate documentation of stabilization and emergency care procedures in accordance with hospital policies and procedures. ♦ A sample of medical records reflecting initial treatment of persons who are determined to have an emergency condition are now monitored weekly by the Medical Director, members of the Medical Staff, Director of Nursing and Director of Assessment & Referral. Deficiencies are immediately addressed and results are tracked, trended, analyzed and used to improve clinical processes. ♦ The Director of Performance Improvement (DPI) will aggregate, analyze and trend the data and present it to Medical Staff, MEC and BOT on a Quarterly basis. ♦ The concurrent tracking and tending tool for September, 2008 was presented in the September Quality Council Meeting on 9/16/08.	

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	Continued From page 1J		♦ The medical director reviews the physician on-call schedule to assure that 24/7 coverage is provided. Any medical supervision issues that arise are reported to the Administrator on Call and to the Medical Director for resolution.	
			Sierra Vista Hospital ensures that the medical staff credentials and privileges providers of radiology services and off-campus consultation services.	10/3/08
			On 9/23/2008 the following actions were initiated. ♦ An application for medical staff membership & privileges is in process for a radiologist who will oversee the quality of care provided by a mobile radiology service affiliated with a Joint Commission accredited radiology organization. ♦ Delineated privileges for radiologists were approved by the medical staff on 9/30/08. ♦ Members of the medical staff with radiology privileges will oversee the quality of care provided by the mobile radiology service and will report evaluation of	10/6/08

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	Continued From page 1K		the quality of care provided to the medical staff and the Board of Trustees quarterly. ♦ A new contract with the mobile radiology service is in process. ♦ Mobile radiology services are provided on order. Patients requiring emergency medical care are transferred to emergency rooms at local hospitals with which SVH has a transfer agreement. ♦ Emergency medical care is evaluated by SVH medical staff review of performance data provided by local hospitals with which SVH has transfer agreements (see POC for A049(3) for methods). Individual(s) responsible: ♦ CEO ♦ Medical Director **How Monitored:** Method of monitoring radiology services will include monthly collection of performance data on quality indicators including timeliness audits, report turn around times, and physician satisfaction with reports received and quarterly reports to the SVH medical staff and Board of Trustees.	

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	Continued From page 72		• Data will be collected monthly and reported quarterly. • Oversight will be provided by the medical staff committee(s) responsible for performance improvement, MEC and the Board of Trustees. Delineated privileges approved by MEC on 9/30/08. Sierra Vista Hospital Governing Board now ensures and radiology and/or Emergency Services will be performed under revised agreements. On 10/1/2008, the following actions were initiated: • A contractor evaluation form was adopted for consistent and systematic data collection. • Quality Indicators have been derived from the form and a tracking and trending process established. • An oversight committee was created by the SVH Medical Director to review quality of care and performance data on all patient care contractors. *Members of this committee* include SVH medical staff, the SVH Regulatory Compliance Officer, and vendor representatives. This committee reports to the Medical staff and	10/1/08 10/1/08 10/1/08

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	Continued From page 7M		MEC and through them to the Board of Trustees no less than annually. Individual(s) responsible: ◆ Medical Director ◆ President of the Medical Staff ◆ Regulatory Compliance officer **How Monitored:** ◆ Patient Care Contracts are reviewed for performance quality by the MEC and Board of Trustees annually. ◆ The Director of PI is responsible for collecting, analyzing & reporting monitoring evidence ◆ Data are reported *to* the Medical Staff, MEC and to the Board of Trustees no less than annually and more frequently if indicated. ◆ **Evidence** Policies: 900.18, 900.20, 900.22, 900.30, 900.40, 900.41, 1000.13 Minutes of the P&T/Infection Control Committee 9/16/08 and 9/30/08 Minutes of Quality Council 9/16/08 and 9/30/08 Minutes of MEC 9/17/08 and 9/30/08 Minutes of the Board of	

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	Continued From page 1N		Trustees 9/30/08 Transfer Agreement Amendment Vendor Evaluation Form Medical staff Minutes of the Medical Policy Committee on 9/24/08	

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A 043	Continued From page 7 emergency services and EMTALA requirements which resulted in a concurrent EMTALA survey. [cross reference A 0092, A 1100] E. To ensure an active program for the prevention, control, and investigation of infections and communicable diseases. [cross reference A 0747, A 0749, A 0750, and A 0756] F. To develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program that involved all hospital departments and services (including those services furnished under contract or arrangement). [cross reference A 0263, A 0265, A 0267, and A 0310] The cumulative effect of these systemic problems resulted in the governing body's inability to govern the hospital effectively in compliance with the statutorily mandated Condition of Participation for Governing Body.	A 043		
A 049	482.12(a)(5) MEDICAL STAFF - ACCOUNTABILITY [The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. This STANDARD is not met as evidenced by: Based on staff interviews, medical record and	A 049	**482.12(a)(5) MEDICAL STAFF ACCOUNTABILITY** The medical staff ensures that care is provided by privileged members of the medical staff and that the quality of care provided is evaluated. Under the direction of the medical staff, on 9/23/2008 the following actions were initiated. 1. A new Service Agreement was written for a local outpatient diagnostic clinical radiology service. This new agreement specifies roles	10/3/08

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A 049	Continued From page 8 document reviews, the governing body failed to ensure that the medical staff was accountable for the quality of care provided to patients as evidenced by: 1) the medical staff arranged for a medical level of care to be delivered by radiologists and specialists who were not members of the medical staff and were not privileged by the hospital to perform those services; the medical staff failed to evaluate the services of those nonprivileged practitioners and report to the Board; 2) the medical staff failed to monitor infection control activities as required by the medical staff bylaws; 3) the medical staff failed to provide quality oversight and supervision for emergency services. 4) the medical staff failed to comply with state and federal laws by permitting registered nurses to perform medical screening exams to rule out emergency medical conditions without the guidance of a standardized procedure, and permitting other clinical staff to perform portions of a medical screening exam beyond the scope of their licensure. Findings: Outlined in Article VIII of the Board of Trustees Bylaws, approved on 11/17/06, were requirements for the Medical Staff to "conduct activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Hospital." These included: 8.3(a) Providing effective mechanisms to monitor and evaluate the quality of patient care and the	A 049	and responsibilities of each organization for the care and supervision of the patient from the time of the hospital physician order to the return of the patient. This document also defines the quality oversight of this service. 2. Radiologists will maintain Hospital medical staff privileges as consultant members. 3. A second agreement for on-site radiology services is in process. 4. Delineated privileges for radiologists were approved by the medical staff on 9/30/08. 5. Members of the medical staff with radiology privileges will oversee the quality of care provided by the mobile radiology service and will report evaluation of the quality of care provided to the medical staff and the Board of Trustees quarterly. 6. Mobile radiology services are provided on order. Patients requiring emergency medical	10/3/08 10/6/08 9/30/08 10/3/08 10/1/08

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A 049	Continued From page 9 clinical performance of individuals with delineated clinical privileges within the Hospital; 8.3(b) Ongoing review, evaluation and monitoring of patient care practices through a systematic process of overall quality assessment and improvement; 8.3(c) Delineation of clinical privileges for Medical Staff members ... and assignment of patient care responsibilities to other health care professionals consistent with individual qualification and demonstrated ability; 8.3(g) Reviewing the competency of care providers who are not subject to the Medical Staff privilege delineation process, and reporting to the governing body of findings with regard to such care providers. The Medical Staff Bylaws, approved 2/25/08, stated in Section 2.2.1 the medical staff was accountable to the Board for the patient care processes and outcomes rendered by all Members ... authorized to practice in the Facility." Medical staff members were obligated, in Section 3.3.1, to "delegate the responsibility for diagnosis or supervision of care of patients only to a Member who has Clinical Privileges to undertake that responsibility." Members were also obligated to abide by the medical staff bylaws, rules and regulations, and all applicable federal and state laws, rules and regulations. 1) The hospital had been previously cited for failures to privilege contracted radiologists who provided a direct level of medical care to hospital patients. As explained in A 0347 and A 0355, patients continued to be sent directly for radiology services where radiologists were not privileged by the hospital to perform a direct level of medical care to hospital patients, and the medical staff	A 049	care are transferred to emergency rooms at local hospitals with which SVH has a transfer agreement. Variances in practice will be identified and analyzed via the risk management system and reported to the medical staff if significant occurrences arise or trends are found. 7. Emergency medical care is evaluated by SVH medical staff review of performance data provided by local hospitals with which SVH has transfer agreements. Individual(s) responsible: ◆ Medical Director ◆ President of the Medical Staff ◆ CEO ◆ Regulatory Compliance Officer **How Monitored:** ◆ Method of monitoring radiology services will include monthly collection of performance data on quality indicators including timeliness audits, report turn around times, and physician satisfaction with reports received and quarterly reports	9/25/08

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A 049	Continued From page 10 had not resolved this organizational flaw. In addition, the medical staff had not arranged for consultants to be credentialed and privileged to perform services for frequently needed medical evaluations (orthopedics, podiatry, cardiology). Despite these arrangements that violated both Board and Medical Staff Bylaws, the medical staff had not evaluated the quality of performance by these off-campus providers and reported to the Board. 2) The Medical Staff Bylaws, approved 2/25/08, obligated the Medical Executive Committee to ensure that the Function of Infection Control was provided. Section 11.4.9 described the Infection Control function duties: a) maintain surveillance of Facility infection potentials; b) develop a system for identifying, reporting, analyzing the incidence and major causes of Facility acquired infections c) develop and implement a corrective action program to minimize infection hazards and evaluate employee health; d) apply specific policies; e) evaluate antibiotic use. As explained in A 0747, A 0748, A 0749, A 0750, and A 0756, there were breaches in medical staff responsibilities related to Infection Control oversight which included hospital employees not screened for tuberculosis, hospital infections not tracked, infection control data not reported to the Board after 2006, and an infection control practitioner (ICP) who lacked the qualifications to perform the duties of ICP. The medical staff failed to ensure that the hospital wide quality assurance program and training programs addressed problems that had been identified by	A 049	to the SVH medical staff and Board of Trustees. Data will be collected monthly and reported quarterly. ♦ A contractor evaluation form has been adopted for consistent and systematic data collection. ♦ An oversight committee was created by the SVH Medical Director to review quality of care and performance data on all patient care contractors. Members include SVH medical staff, the SVH Regulatory Compliance Officer, and vendor representatives. This committee reports to the Medical staff and MEC and through them to the Board of Trustees no less than annually. ♦ Oversight will be provided by Quality Council, MEC and the Board of Trustees through regular agenda items. The Sierra Vista medical staff now monitors infection control activities as required by the bylaws. Under the direction of the medical staff, on 8/11/2008 the following actions were initiated. 1. An evaluation of the Infection Control Program was completed by an external Best Practices	9/30/08

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A 049	Continued From page 11 the infection control practitioner (ICP), and were responsible for the successful corrective action plans in those affected areas. When asked on 7/16/08 at 4 p.m. if they were aware that there was no evidence that ICP had submitted infection control reports to the Pharmacy and Therapeutics Committee or to the Quality Assurance Committee, administrative staff stated that was why the hospital had made some management changes. Administrative staff also confirmed that there was no documentation showing that after 2006, the Governing Board had been notified about the infection control reports or the infection control plan. 3) The responsibility of the Medical Staff, according to Section 2.2.1(e) of the 2/25/08 Medical Staff Bylaws, was to account to the Board for the patient care processes and outcomes rendered by all [practitioners] through "active involvement in the measurement, assessment, and improvement of patient care processes and outcomes through a valid and reliable quality management program." As explained in A 0347, A 1103, A 1104 and A 1111, the emergency services provided to unscheduled walk-in Assessment and Referral patients did not comply with seven hospital policies and procedures (900.18, 900.19, 900.20, 900.22, 900.23, 900.24, 900.3), medical staff rules and regulations (Sections 17 and 21), and EMTALA regulations(CFR 489.20 and 489.24). Emergency services were not directly supervised by a qualified member of the medical staff who was immediately available to patients with emergency medical conditions at all times emergency services were offered. A&R patients	A 049	expert on 9/8/-08 through 9/12/08. ◆ Based on the evaluation, the Medical Staff comprehensively revised the Infection Control Program Policies and Procedures; these were approved by the Medical Staff on 9/16/08 and 9/17/08. 2. Infection Control data were presented to the medical staff on 9/16/08 and 9/17/08 consistent with requirements in article 8.3(b) of the Board of Trustees Bylaws and Section 11.4.9 (a) through (c.) of the Medical staff Bylaws. 3. The report of the Annual evaluation was made to the medical staff on 9/30/08. Individual(s) responsible: ◆ Medical Director ◆ President of the Medical Staff ◆ Regulatory Compliance Officer ◆ Infection Preventionist The Sierra Vista medical staff now provides quality oversight and supervision of emergency services.	9/30/08 9/30/08

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	Continued From page 12		1. QI monitoring of the quality of emergency services care provided both on and off campus has been initiated through systematic data gathering and analysis of quality indicators, chart review of care provided to patients found to have an emergency medical condition, and review of quality performance data from off campus providers of emergency care.	9/30/08
			2. Sierra Vista Hospital now ensures that all emergency care is supervised by a qualified member of the medical staff.	8/1/08
			Individual(s) responsible: ♦ Medical Director ♦ President of the Medical Staff	
			The Sierra Vista Hospital Medical Staff now ensure compliance with state and federal laws, including standardized procedure requirements. Under the direction of the medical staff, in July, 2008, the following actions were initiated. 1. Training of RNs in accordance with an approved standardized procedure.	9/24/08
			2. Monitoring of competency by a physician or a qualified QMP RN via proctoring in the performance of Medical Screening Exams.	8/1/08
			3. Oversight of RN performance	

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	Continued From page 12A		of Medical Screening Exams by SVH designated members of the SVH medical staff.	8/1/08
			4. Approval of the standardized procedure and creation of an Interdisciplinary Practices Committee by the Medical Policy Committee of the SVH medical staff on 9/24/08 and MEC and Board of Trustees on 9/30/08.	9/30/08
			Individual(s) responsible: ◆ Medical Director ◆ President of the Medical staff ◆ DON-QMP RN Trainer ◆ Regulatory Compliance Officer	
			How Monitored: ◆ Method of monitoring is via 100% audit of MSE documentation for completeness, accuracy, and adherence to the standardized procedure. Variances are addressed via remedial education. ◆ Oversight of findings / compliance data or other evidence by the Interdisciplinary Practices Committee, with reports to the MEC and Board of Trustees.	
			Evidence: Minutes of Quality Council 9/16/08	

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	Continued From page 12B		and 9/30/08, MEC 9/30/08, P&T 8/19/08, 9/16/08 and 9/30/08	

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A 049	Continued From page 12 did not receive emergency services comparable to patients throughout the hospital and within the capability of the hospital. These deficiencies were not identified by an event-driven quality assessment and performance improvement system, and were not reported to the governing board. 4) As explained in A 0347, A 1111 and A 1112, the hospital was providing emergency services and was subject to EMTALA requirements. Assessment and Referral staff described practices for evaluating unscheduled walk-in patients that included medical screening exams by registered nurses who were not appropriately trained and without the guidance of a standardized procedure in accordance with state law. Medical screening exams were also conducted by social workers and clinicians who were not approved Qualified Medical Personnel (per medical staff rules and regulations Section 21) and were not permitted delegation of this task by a physician in accordance with state law (California Medical Practice Act).	A 049		
A 084	482.12(e)(1) CONTRACTED SERVICES 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:	A 084	**482.12(e)(1) CONTRACTED SERVICES** The Sierra Vista Hospital Governing Board now ensures that services performed under transfer agreements with local acute care hospitals are safe, effective, evaluated for quality of the services. On 10/1/2008, the following actions were initiated: 1. A contractor evaluation form has been adopted for consistent and	10/2/08

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A 084	Continued From page 13 Based on staff interviews, medical record and document reviews, the governing body failed to ensure that services performed under transfer agreements with local acute care hospitals (for 2 of 2 transfer agreements reviewed) were safe, effective, permitted assessment for quality of the services, and included specific tasks needed by the home hospital. The hospital also permitted services to be performed by a suspended vendor. Findings: Policy 900.26 Contract Services, revised 10/06, listed the services provided by contract or agreement as Radiology, Laboratory, Emergency Services, MRI services, and others. The procedure included to "stipulate the referral process and establish the mechanism for monitoring quality" and to monitor for quality through the Performance Improvement Process. Section 3.10(b) of the 11/16/06 Board of Trustees Bylaws obliged the Board to assure that all individuals, who provided patient care services but who were not subject to the Medical Staff privilege delineation process, were competent to provide such services. In addition, the Board expected to receive reports of quality assurance information regarding competency of care providers not subject to the privilege delineation process. A Transfer Agreement Between [Hospital A] and SVH dated 4/15/08 was reviewed on 7/22/08. The agreement described (in the Determining Need for Transfer section) provisions for admitting and readmitting patients between the two facilities. Under the Conditions to Transfer section, reference was made to meeting	A 084	systematic data collection. 2. Quality Indicators have been derived from the form and a tracking and trending process established. 3. An oversight committee was created by the SVH Medical Director to review quality of care and performance data on all patient care contractors. Members include SVH medical staff, the SVH Regulatory Compliance Officer, and vendor representatives. This committee reports to the Medical staff and MEC and through them to the Board of Trustees no less than annually. 4. A Transfer Agreement amendment was finalized on 9/25/2008 for both local hospitals contracted with the Hospital. • This Amendment has been reviewed by Methodist Hospital and Kaiser Foundation Hospital South legal departments and has been approved. 5. A new Service Agreement was written for a local outpatient diagnostic clinical radiology service. This new agreement specifies roles and responsibilities of each organization for the care and	10/2/08 10/2/08 9/25/08 10/2/08 10/2/08

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A 084	Continued From page 14 "admission criteria relating to appropriate bed, personnel, and equipment necessary to treat the patient." Certain essential information was to be exchanged between the facilities "as promptly as possible." Non-emergency care was to be arranged in advance. The agreement required Hospital A to make available to the patient its outpatient diagnostic and therapeutic services as designated by the attending physician subject to federal and state laws and regulations. The agreement did not explain who the attending physician would be (the SVH psychiatrist, the inpatient attending at Hospital A, or an emergency department practitioner at Hospital A); and did not delineate the specific services such as STAT labs, x-ray, MRI, CT, specialty consultation (cardiology, orthopedic, neurology). The agreement did not distinguish a formal transfer between inpatient services (or inpatient to emergency room and vice versa), from temporary movement from one facility to another for outpatient services. On 7/18/08 at 5 p.m. transfer agreements between the hospital and two neighboring acute care hospitals were discussed with CEO of SVH. The CEO acknowledged that neither agreement listed the specific emergency and outpatient services (lab, x-ray, specialty consultation, preliminary and final reports) desired and needed for SVH patients. Nor was there language that established a formal expectation for treatment records to be provided to SVH at the time the service was rendered (or when available) by the other hospitals. The agreements did not establish a means of communicating information (staff communication, mail, fax) that optimized the delivery of care and hand-off from one hospital to the other. Although the agreement with Hospital	A 084	supervision of the patient from the time of the hospital physician order to the return of the patient. This document also defines the quality oversight of this service. 6. Radiologists will maintain Hospital medical staff privileges as consultant members. 7. A second agreement for on-site radiology services is in process. Individual(s) responsible: ◆ CEO ◆ Medical Director ◆ President of the Medical Staff ◆ Regulatory Compliance Officer **How Monitored:** ◆ Patient Care Contracts are reviewed for performance quality by the MEC and Board of Trustees annually. ◆ The Director of PI is responsible for collecting, analyzing & reporting monitoring evidence ◆ Reports will be made to the Medical Staff, MEC and through them to the Board of Trustees no less than annually	10/2/08 10/2/08

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A 084	Continued From page 15 B provided access for that hospital to review QAPI data, credentialing and peer review information for SVH operations and providers, there was no reciprocal agreement for SVH to review the same information for operations and providers at Hospital B. The Hospital A agreement had no provision for SVH to access QAPI data or provider performance information to fulfill its oversight obligation of the contracted services. The CEO in an interview conducted on 7/23/08 at 6:15 p.m., echoed previous statements by the Risk Manager that quality assessments for contracted services were event driven, except for a few vendors that provided reports. For example, the laboratory contractor provided reports about timeliness of responding to lab requests and turnaround times. CEO stated she attended meetings at the neighboring hospitals where some quality reports were shared. However, specifically for SVH patients transferred to these hospitals, the hospitals did not provide data reflecting the numbers of hospital acquired infections, adverse outcomes (death or disability), medication errors, or x-ray overread statistics on radiologists who read films on SVH patients. Such information could serve as an ongoing and objective source of quality assessment for the services provided to SVH patients by the other hospitals. The agreements did not permit SVH to directly audit operations of the other hospitals. CEO acknowledged the contract with the eye and tissue bank was not integrated into the hospital's quality oversight despite the death of Patient 8 in February 2008, which was an event opportunity to capture a review of this contract. A previous complaint validation survey in	A 084	and more frequently if indicated. ◆ Copy of evidence ○ Vendor Evaluation Form ○ Quality Indicator Tracking and Trending Plan ○ Amendment to Transfer Agreement	

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A 084	Continued From page 16 February 2008 found that radiologists under contract who were reading films taken by a contracted mobile x-ray company were not granted privileges to provide this direct medical level of care for SVH patients. As a result of the finding, CEO indicated that the contracts with the radiology vendors were suspended. A formal decision to suspend those contracted services did not occur until the May 19, 2008 Medical Executive Committee Ad Hoc meeting (approval noted in meeting minutes). During the present survey, Patient 13 was sent to one of the suspended vendors for a wrist MRI on 7/15/08. Hospital staff (PHY F, PHY I, PHY J, A/B Unit Manager, RN 7) were not familiar with the restriction for radiologic services to just the two contracted hospitals through their emergency rooms. (Refer to A 0346, A 0546 and A 1103) CEO acknowledged that the local hospital did not have an open MRI capability and that for patients who need an open MRI, the hospital had no active agreement (that complied with the conditions of participation) to render the service. CEO produced an outdated amendment (from 1987 and 1989) to the agreement with Hospital A for outpatient services including radiology services. Each partner of the agreement had changed ownership several times and the document was not currently valid. CEO planned to revise the current transfer agreements to specify the outpatient services desired, timeliness of medical records and reports, and to seek specialty consultation services.	A 084		
A 092	482.12(f)(1) EMERGENCY SERVICES If emergency services are provided at the hospital, the hospital must comply with the requirements of §482.55.	A 092	**482.12(f)(1) EMERGENCY SERVICES** Sierra Vista Hospital now ensures	

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A 092	Continued From page 17 This STANDARD is not met as evidenced by: Based on observation, staff interviews, medical record and document reviews, the hospital failed to comply with the requirements of CFR 482.55, the Condition of Emergency Services, as evidenced by: 1. failure to integrate into the emergency department the services that were available to the inpatient units such that patients presenting with emergency medical conditions received stabilizing treatment within the capability of the hospital and equivalent to treatments offered to inpatients [cross reference A 1103]; 2. failure to ensure timely and effective communication between off-campus emergency providers authorized to provide care under a transfer agreement [cross reference A 1103]; 3. failure to ensure emergency policies and procedures were followed by hospital staff [cross reference A 1104]; 4. failure to ensure that emergency services were supervised by a qualified member of the medical staff during all periods that emergency services were offered and available [cross reference A 1111]; 5. failure to ensure that personnel (RN's) providing medical screening exams and stabilizing treatment to patients with emergency medical conditions were qualified and functioned in accordance with state laws. The hospital permitted social workers and clinicians to perform	A 092	compliance with the requirements of CFR 482.55, the condition of emergency services. 1. The facility now ensures that the services available to inpatient units are integrated into the Assessment and Referral area such that patients presenting with emergency conditions receive stabilizing initial treatment with the capability of the hospital and equivalent to treatments offered to inpatients. a. All patients presenting for an unscheduled assessment who are deemed to have an emergency medical condition (EMC) will receive stabilizing treatment within the capability of the hospital. b. Clinical Services Policies, **900.18** *Emergency Screening and Initial Assessment*, **900.20** *Medical Screening Exam* and **900.22** *Emergency Care* were amended to include clear guidelines for the role(s) and function(s) of the physician and RN QMP to oversee and provide supervision and stabilization based on assessed patient needs. c. Sierra Vista Hospital now ensures that it does not	10/2/08

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	Continued From page 18		solely rely on 911 emergency services, and does provide initial appraisal and stabilizing treatment within the hospital's capability and capacity.	10/2/08
			2. Sierra Vista Hospital now ensures timely and effective communication between the hospital and off-campus emergency providers authorized to provide care under a transfer agreement. a. The hospital's transfer agreement has been amended and now requires compliance by contracted hospitals. Transfers are audited to assure documentation is received.	10/2/08
			3. Sierra Vista Hospital now ensures that emergency policies and procedures are followed by hospital staff. a. RN's working in the Assessment and Referral department (A & R) were educated regarding the appropriate management of patients presenting with an EMC as defined in **Policies 1000.13** *Major Medical Emergency Treatment*	

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	Continued From page 18A		and **900.22** the *Emergency Care.* b. Training included appropriate utilization of emergency equipment and calling a Code Blue.	10/2/08
			4. Sierra Vista Hospital now ensures that all emergency care is supervised by a qualified member of the medical staff.	10/2/08
			5. Sierra Vista Hospital now ensures that RNs providing medical screening exams (MSE) and stabilizing treatment to patients with emergency medical conditions (EMC) are qualified and functioned in accordance with state laws. a. A new policy was developed (*Standardized Procedure for Qualified Medical Personnel-Registered Nurses #900.40)* to define the standardized procedures for QMP RNs in accordance with the Title 22, the Nurse Practice Act, and Guidelines for Standardized Procedures and was given final approval on 9/30/2008. b. Training was provided to all RN's who met the	

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	Continued From page 18B		qualifications in the Standardized Procedure. c. Competency assessment and proctoring for QMP's trained was completed by QMP MD's. d. An *Interdisciplinary Practices Committee* was established via **Policy 900.41** on 9/24/2008 to ensure the oversight functions related to Standardized Procedures in accordance with Title 22. The IDP Committee reports to MEC and the Board of Trustees. Individual(s) responsible: ◆ Medical Director ◆ Director of Nursing ◆ Director of Assessment and Referral ◆ COO **How Monitored:** ◆ The A & R QI Indicator Tool, which evaluates the completion of the Medical Screen components, stabilization documentation and authorization for transfer form (if applicable) will be monitored on a weekly basis by the Director of A & R. Identified trends will be corrected through staff	

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	Continued From page 18C		education and staff disciplinary procedures. ◆ The Director of Assessment and Referral maintains a copy of all *Authorization for Transfer* forms and reviews 100% of the forms for completeness to assure documentation of care and transfers are accurately completed. ◆ Management of emergency care will be monitored via daily review by the A&R Director of the incident report log and 100% of face to face assessments for adequate documentation of stabilization and emergency care procedures in accordance with hospital policies and procedures. ◆ A sample of medical records reflecting initial treatment of persons who are determined to have an emergency condition are now monitored weekly by the Medical Director, members of the Medical Staff, Director of Nursing and Director of Assessment & Referral. Deficiencies are immediately addressed and results are tracked, trended, analyzed and used to improve clinical processes. ◆ The Director of Performance	

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	Continued From page 185		Improvement (DPI) will aggregate, analyze and trend the data and present it to Medical Staff, MEC and BOT on a Quarterly basis. ♦ The concurrent tracking and tending tool for September, 2008 was presented in the September Quality Council Meeting on 9/16/08. ♦ The medical director reviews the physician on-call schedule to assure that 24/7 coverage is provided. Any medical supervision issues that arise are reported to the Administrator on Call and to the Medical Director for resolution. ♦ evidence Policies: 900.18, 900.20, 900.22, 900.30, 900.40, 900.41, 1000.13 Memo to A&R RN's QMP Training Module Sample audit tool Tracking and trending tool Medical Staff schedules Minutes of Quality Council 9/16/08 Minutes of MEC 9/17/08 Transfer Agreement Amendment	

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A 092	Continued From page 18 portions of the medical screening exam in violation of the medical staff rules and regulations. [cross reference A 1112]	A 092		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on observation, staff interviews, medical record and document reviews, the hospital failed to develop, implement and maintain an effective, ongoing hospital-wide, data-driven quality assessment and performance improvement program. The program failed to involve all hospital departments and services (including those services furnished under contract or arrangement) as evidenced by:	A 263	**482.21 QAPI** The Sierra Vista Hospital Governing Board now ensures that all below identified departments are evaluated for quality of the services. A) Non-privileged radiologists B) Non-privileged consultants C) Emergency Services. D) Assessment and Referral E) QI Dietary indicators F) Infection Control G) Ongoing Program for Quality Improvement H) Potential Organ Donor On August 20, 2008, the following actions were initiated. 1. All hospital performance improvement data for July, 2008 was aggregated and reported to Medical Staff and Medical Executive Committee. 2. All minutes to Medical Staff Committees reflected the aggregate data reporting information. On September 16, 2008 the following actions were initiated. 1. All hospital performance	9/1/08 9/1/08 9/30/08

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A 263	Continued From page 19 A. The QAPI program failed to evaluate the effectiveness of services provided by non-privileged radiologists (under transfer agreement) and under contract with a suspended vendor (Refer to A 0267); B. The QAPI program failed to evaluate the effectiveness of services provided by off-campus non-privileged consultants (Refer to A 0267); C. The QAPI program failed to evaluate the effectiveness of emergency services provided by nearby hospitals under a transfer agreement (Refer to A 0084 and A 0267); D. The QAPI program failed to evaluate the effectiveness of services provided by the Assessment and Referral Department (Refer to A 0267): E. The QAPI program failed to ensure that the dietary department's performance improvement program was comprehensive (Refer to A 0265); F. The QAPI program failed to evaluate the effectiveness of the infection control program and activities (Refer to A 0267); G. The hospital's governing body, medical staff, and administrative officials failed to ensure that an ongoing program for quality improvement was effectively implemented and maintained (Refer to A 0310); H. The QAPI program failed to identify omission of reporting a potential organ donor to the designated organ procurement agency (Refer to A 0886).	A 263	improvement data for August, 2008 was aggregated and reported to Medical Staff and Medical Executive Committee. 2. All minutes of Medical Staff Committees reflected the aggregate data reporting information. 3. A new format for reporting concurrent PI audit tools for identified Hospital departments (i.e., A & R, Infection Control, Pharmacy, Dietary) were processed and implemented on Oct 1, 2008. On September 24, 2008, the following actions were initiated on organ procurement. 1. A meeting was held with the Director of Golden State Donor Service with the following agenda: a. Policy Review and Revision b. Definition of "Imminent Death" c. Annual Review of Death d. Schedule for Staff Training e. Signature approval of Finalized Policy 2. The policy was reviewed and amended to meet the intent of the contract agreement for organ, tissue and eye	9/30/08 9/30/08 9/24/08 9/24/08

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	Continued From page 20		procurement between Sierra Vista Hospital and DCI Donor Services, Inc., d/b/a Sierra Eye and Tissue Donor Services (SETDS)/Golden State Donor Services and to include a definition for "imminent death." Signature approval by the Golden State Donor Services and the CEO was completed.	
			3. An annual review of the single death occurring in 2008 was done. The Golden State Donor Services representative concluded that the death of patient 1 could not be declared at SVH as resuscitation was still in progress and the patient's condition did not meet the agreed upon definition of "imminent death".	9/24/08
			4. Training for staff was scheduled for 9/30/08 to be conducted by the Golden State Donor Services representative. All future training on OPO will be conducted by the Director of Nursing or designee.	10/6/08
			On October 1, 2008 the following actions were initiated for contracted emergency services (i.e., non-privileged consultants and radiology)	
			1. Tracked and trended through our variance reporting	10/1/08

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	Continued From page 20A		systems and reported quarterly to Medical Committees on Quality and yearly through contract renewal audits. Individual(s) responsible: ◆ Director of PI ◆ CEO ◆ Regulatory Compliance Officer ◆ Department Directors: A&R, Infection Preventionist, Pharmacy and Dietary **How Monitored:** ◆ Quality Council Minutes will be monitored by the Regulatory Compliance Officer for thoroughness of PI reporting. ◆ A regular compliance report will be made to MEC and the Board of Trustees ◆ Copy of evidence o Medical Staff minutes for August 20,2008 and September 16, 2008 and Quality Council, MEC and Board of Trustees minutes of September 30, 2008 o July and August Quality Indicator Graphs o Quality Indicator tracking sheets for contractor performance, A&R department, Infection Control, Dietary, and Organ Procurement	

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A 263	Continued From page 20 The cumulative effects of these systemic problems resulted in an ineffective QAPI program that did not involve all hospital departments and services in compliance with the statutorily mandated Condition of Participation for Quality Assessment and Performance Improvement.	A 263		
A 265	482.21(a)(1) QAPI HEALTH OUTCOMES The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes. This STANDARD is not met as evidenced by: Based on performance improvement staff interview and performance improvement document review the hospital failed to ensure the implementation of a comprehensive dietary department performance improvement program that included performance improvement indicators relative to the current scope of service as evidenced by lack of activities surrounding identified food service and nutrition care issues. Findings: Review of the dietary department performance improvement activities occurred on 7/17/08 at 1:30 p.m., with Registered Dietitian and the Director of Dietary Services. Review of the performance improvement indicators revealed that the clinical nutrition care parameters dealt	A 265	**482.21(a)(1) QAPI HEALTH OUTCOMES** Sierra Vista Hospital now ensures implementation of a comprehensive dietary department performance improvement program that includes performance improvement indicators relative to the current scope of service. On 10/1/ 08 the following actions were initiated: ♦ New dietary department PI indicators were approved by the Quality Council, including: • Nutrition screen completed with BMI • Diets are provided consistent with the approved diet manual • Nutrition care plans are completed for patients receiving dietary modifications or interventions • Dietary consults are completed timely.	9/30/08

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A 265	Continued From page 22 continuity sheet. While data was being collected for these parameters there was no specific analysis of the data, rather the data was being gathered nightly with the intent that any deficiencies would be corrected by the next 24-hour period. It was also noted that on the July 15, 2008 quality council minutes that the dietary department was scheduled to present their quarterly report; however there was no documentation of who attended the meeting or the data that was presented. Similarly there was no discussion of performance improvement activities for nutrition care or dietary services at the Board of Directors meeting.	A 265		
A 267	482.21(a)(2) QAPI QUALITY INDICATORS The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations. This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to ensure that quality indicators measured, tracked, and analyzed: 1. the processes of patient care as related to infection control; 2. the performance of nonprivileged radiologists and off-campus practitioners who provided a medical level of care to hospital patients to assess the effectiveness of their services; and 3. the performance of A&R activities in an accurate and effective manner.	A 267	**482.(a)(2) QAPI QUALITY INDICATORS** *Sierra Vista Hospital now measures, analyzes and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations.* *1. Infection Control* On September 23, 2008, the following actions were initiated. a. Identified Infection Control Quality Indicators as follows: PPD testing, Flu and Hepatitis B monitoring for staff, and Hand Hygiene. Individual(s) responsible: ♦ Infection Preventionist	9/23/08

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A 265	Continued From page 21 with the timeliness of nutrition assessments, appropriateness of assigned nutrition care levels and the completion of physician ordered nutritional consults within 48 hours. It was noted that all elements for 2007 were above the 90% benchmark level determined by the hospital; however it was also noted that the recommendation for physician ordered nutrition consults was to continue to monitor despite lack of problem identification. These elements were also recorded for the first quarter of 2008 with the continued recommendation to continue monitoring. Review of dietary services monitoring activities noted data collection related to food, dish machine and refrigerator/freezer temperatures. It was also noted that the resulting compliance, with the exception of 1 month, was 100%. There was no documented evidence that the performance improvement program for either nutrition care or dietary services was developed in response to an identified problem, rather it continued to be data collection on parameters for which no problem was identified. Review of the dietary department performance improvement activities occurred on 7/17/08 at 2:30 p.m. in conjunction with the Director of Risk Management and revealed that currently the dietary department did not have a performance improvement program. Review of hospital-wide department specific indicators for June and July 2008, revealed the hospital wide indicators were developed in response to survey deficiencies in 2/08. It was also noted that the dietary parameters that were being reported included the diet indicated on admission orders, completion of nutritional screen and the diet indicated on	A 265	Individuals responsible: • Director of Dietary Department • Director of PI **How Monitored:** • Data will be collected monthly by the Dietary Department Director • The PI director will aggregate, analyze and trend the data on a monthly basis • Reports will be made quarterly to the Quality Council. ♦ Copy of Evidence o Dietary Department PI tracking and trending worksheet	

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A 267	Continued From page 23 Findings: 1. Infection Control On 7/15/08 at 8:30 a.m., a request was made to to review the hospital's quality assessment performance improvement (QAPI) plan for infection control. On 7/15/08 at 10:45 a.m., administrative staff stated that the infection control practitioner (ICP) had the infection control QAPI program plan with her. On 7/16/08 at 12:35 p.m., the ICP was interviewed. The ICP provided copies of the hospital's 2006 infection control plan, and the infection control program yearly report for 2006. The 2006 infection control plan was reviewed and the following was noted: The two page plan consisted of five sections, purpose, objectives, organization, surveillance indictors, and outbreaks. Under the section titled organization, the infection control plan directed that the infection control committee was responsible for the surveillance of nosocomial infections, at risk processes, review and analysis of data related to incidence and causes of infections. Under the organization section the infection control plan also directed that, "As a member of the Hospital Pharmaceuticals and Therapeutics Committee, quarterly report and infection control issues shall be presented." The 2006 infection control program yearly report	A 267	♦ Director of PI **How Monitored:** ♦ All will be monitored and collected monthly by the Infection Preventionist ♦ All data will be reported to Director of PI for aggregate and trending purposes and the results reported to the Quality Council. ♦ Infection Control Manual revised and presented to Quality Council on September 18, 2008. ♦ Copy of evidence: Minutes of Infection Control Committee and Quality Council September, 2008. 2. <u>Non-privileged radiologists</u> On 9/23/2008 the following actions were initiated. a. An application for medical staff membership & privileges is in process for a radiologist who will oversee the quality of care provided. b. Delineated privileges for radiologists were approved by the medical staff on 9/30/08. c. Member of the medical staff with privileges in radiology will oversee the quality of radiologic care provided and will report evaluation of the	10/03/08 9/30/08 10/03/08

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A 267	Continued From page 24 was reviewed. The yearly infection control report documented the number of inpatients who developed infections. The infections listed included one case of positive tuberculosis, ten cases of Hepatitis C, four cases of MRSA (methicillin resistant staphylococcus aureus), and six cases of scabies. During the interview, the ICP could provide no evidence that these infection control issues had been analyzed by the hospital. The ICP practitioner also stated that she had not measured tracked, analyzed or reported any infection control information after 2006. On 7/16/08 at 4 p.m., the Chief executive officer (CEO), confirmed that hospital had no evidence that the ICP had measured, analyzed, or tracked infection control quality indicators or that processes of care related to infection control had been assessed by the ICP and reported to the medical staff, management staff, or the governing body. 2. Performance of nonprivileged practitioners In an interview with the Medical Staff Coordinator (MSC) on 7/18/08 at 3 p.m., a copy of the Medical Staff Roster was reviewed. The Roster did not contain any radiologists. The Roster listed as consultant staff two family physicians, one neurologist and one psychologist. The MSC had not collected any performance evaluations for radiologists reading x-rays for Patients 1, 13, 20, or 21. The MSC had not collected any performance evaluations for the orthopedist who treated Patient 13, or for the podiatrist who treated Patient 1.	A 267	quality of care provided to the medical staff and the Board of Trustees quarterly. d. Mobile radiology services are provided on order. Patients requiring emergency medical care are transferred to emergency rooms at local hospitals with which SVH has a transfer agreement. e. Emergency medical care is evaluated by SVH medical staff review of performance data provided by local hospitals as specified in the addendum to the transfer agreements. Individual(s) responsible: ♦ CEO ♦ Medical Director ♦ Regulatory Compliance Officer ***How Monitored:*** ♦ Method of monitoring radiology services will include monthly collection of performance data on quality indicators including timeliness audits, report turn around times, and physician satisfaction with reports received and quarterly reports to the SVH medical staff and Board of Trustees. ♦ Data will be collected monthly and reported quarterly. ♦ Oversight will be provided by the Quality Council, MEC and	10/06/08 10/06/08

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A 267	Continued From page 25 In an interview with the Risk Manager on 7/18/08 at 11:50 a.m., the Risk Manager stated the Quality Assessment program activities were event driven. The Risk Manager provided reports for events related to transfers to an off-campus emergency room that included the occasions when Patient 1 and Patient 13 received x-ray care and consultations with nonprivileged practitioners. The reports did not measure, analyze or evaluate the quality of service provided by those practitioners. The Risk Manager could produce no other objective reflection of the services provided by the nonprivileged radiologists and consultants. Similarly, the Risk Manager could provide no objective evidence for the performance of contracted partners, specifically for Hospital A and Hospital B, who had transfer agreements with the hospital. The Risk Manager had no process to directly access data from those hospitals that reflected the quality of performance for the services they provided to hospital patients, such as rates of hospital acquired infections, medication errors, preventable deaths, falls, delays in treatment, x-ray overreads, or timeliness and consistency of providing medical records. Although the hospital reported only one death in the past year, they were not able to track the outcomes for patients transferred to an acute care hospital who may die (or become disabled) subsequently at the other hospital to evaluate relationships between care here and an adverse outcome. 3. Accurate A&R Evaluation Review of 30 A&R walk-in patients' medical records, for scheduled and unscheduled patients,	A 267	the Board of Trustees. 3. A & R In August, 2008 the following actions were initiated. a. Developed an Assessment and Referral (A & R) QI Indicator Tool for 100% Concurrent reviews to begin on September 1, 2008. The following indicators are now being tracked and monitored weekly: 5150 Completed Accurately and Completely if Applicable, Medical Screening Completed, Consent for Assessment, On Cobra Log, Checked for durable medical equipment, EMTALA Completed, Total calls entered into HMS, Total calls with supplemental Documentation. Individual(s) responsible: ♦ Director of A & R ♦ Director of Performance Improvement ***How Monitored:*** ♦ The A & R QI Indicator Tool will be monitored and corrected through staff education on a weekly basis by the Director of A & R. ♦ The Director of Performance	8/31/08

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A 267	Continued From page 26 in conjunction with staff interviews, determined that A&R patients were evaluated and processed contrary to A&R policies and procedures. For 27 of the 30 patients (Patients 35, 36, 37, 38, 39, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63), the hospital failed to provide a qualified medical person to evaluate the patients for the presence of an emergency medical condition per Policy 900.18. For 11 unscheduled patients with emergency medical conditions (Patients 37, 39, 41, 42, 43, 46, 50, 54, 58, 60, 63), the hospital failed to provide stabilizing treatment within the capability of the hospital (Policy 900.18, 900.19). For 12 unscheduled patients with emergency medical conditions (Patients 35, 37, 39, 41, 42, 43, 46, 50, 54, 58, 60, and 63), and 6 scheduled patients with emergency medical conditions (Patients 36, 38, 47, 52, 53, 57), the hospital failed to arrange for safe transportation and appropriate transfers (Policy 900.22). The hospital failed to maintain an organized and accurate central log for emergency patients (Policy 900.24). (Refer to A 0023, A 1079, A 1103 and A 1104) In an interview with the Risk Manager on 7/31/08 at 12:40 p.m., the Risk Manager stated the activities of the Assessment and Referral department were evaluated annually (1 year review). At the last review, the A&R Director provided reports to the Quality Committee which showed 100% compliance in the selected indicators. The Risk Manager was asked to provide quality assessment documentation for the accuracy and completion of A&R activities including the ER log, completion of the A&R packet, completion of transfer forms, ensurance of safe transfers, and medical staff approval of the training method for the Qualified Medical	A 267	Improvement (DPI) will aggregate, analyze and trend the data or Medical Staff Committee(s) on a Quarterly basis. ◆ Frequency of monitoring: Quarterly ◆ Oversight of findings / compliance data or other evidence by the Director of PI and reported to Quality Council. ◆ The ongoing concurrent audit tool for September, 2008 was presented in the September Quality Council Meeting. ◆ Copy of evidence o Quality Council Minutes for September, 2008 o A & R PI Concurrent Audit Tool	

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A 267	Continued From page 27 Personnel Registered Nurse. These requested items were not produced prior to the survey exit on 8/1/08. The QAPI activities that addressed oversight of emergency and outpatient services from the A&R department did not identify noncompliant practices of A&R, and thereby could not evaluate the effectiveness of this department.	A 267		
A 310	482.21(e)(1) EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring that an ongoing program for quality improvement is defined, implemented, and maintained. This STANDARD is not met as evidenced by: Based on staff interviews, medical record and document reviews, the governing body, medical staff and administrative officials failed to ensure: 1. the QAPI reviews for competency of all individuals who provide patient care services were implemented and maintained; 2. the QAPI reviews for services provided to patients treated in the Assessment and Referral Department (A&R) accurately reflected the activities performed in A&R; 3. the QAPI reviews for Other Services, i.e., infection control, contracted services, dietary department practices, and organ procurement	A 310	**482.21(e)(1) EXECUTIVE REPONSIBILITIES** Sierra Vista Hospital Governing Board now ensures and radiology and/or Emergency Services will be performed under revised agreements. On 10/1/2008, the following actions were initiated: 1. A contractor evaluation form was adopted for consistent and systematic data collection. 2. Quality Indicators have been derived from the form and a tracking and trending process established. 3. An oversight committee was created by the SVH Medical Director to review quality of care and performance data on all patient care contractors. *Members of this committee* include SVH medical staff, the SVH Regulatory Compliance	10/1/08 10/1/08 10/1/08

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A 310	Continued From page 28 opportunities, were implemented and maintained. Findings: 1. Provider Competency Stated in the Board of Trustees Bylaws, approved on 11/17/06, in Section 3.10 were two responsibilities of the Board: a) to provide Medical Staff oversight and quality care evaluation, and b) to assure that all individuals who provide patient care services, but who are not subject to the Medical Staff privilege delineation process, are competent to provide such services, and receive reports of quality assurance information regarding competency of care providers not subject to the privilege delineation process. The Board also delegated to the Medical Staff, in Section 8.3(c), the responsibility to assure that all individuals responsible for the assessment, treatment or care of patients were competent in the ability to obtain information and interpret information in terms of the patient's needs. The medical staff in its own bylaws, approved 2/25/08, defined its purpose (section 2.1.1) to ensure that all patients receive uniform quality patient care. Section 4.3 designated a category of medical staff practitioners, Consulting Staff, who were to consult at the request and direction of a Member of the Active or Courtesy Medical Staff. Consulting Staff and Contracting Staff (section 6.9.2) were required to meet the qualifications and be processed for appointment with assignment of clinical privileges comparable to general members of the medical staff.	A 310	Officer, and vendor representatives. This committee reports to the Medical staff and MEC and through them to the Board of Trustees no less than annually. 4. A Transfer Agreement amendment was finalized on 9/25/2008 for both local hospitals contracted with the Hospital. • This Amendment has been reviewed by Methodist Hospital and Kaiser Foundation Hospital South legal departments and has been approved. 5. A new Service Agreement was written for a local outpatient diagnostic clinical radiology service. This new agreement specifies roles and responsibilities of each organization for the care and supervision of the patient from the time of the hospital physician order to the return of the patient. This document also defines the quality oversight of this service. 6. Radiologists will maintain Hospital medical staff privileges as consultant members. 7. A second agreement for on-site radiology services is in process.	10/3/08 10/3/08 10/3/08 10/6/08

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 310	Continued From page 29 As explained in A 0347, the medical staff failed to evaluate the qualifications and performance of 2 specialty consultants and 5 radiologists performing a medical level of care to SVH patients. In an interview with the Medical Staff Coordinator (MSC) on 7/18/08 at 3 p.m., a copy of the Medical Staff Roster was reviewed. The Roster did not contain any radiologists. The Roster contained as consultant staff two family physicians, one neurologist and one psychologist. The MSC had not collected any performance evaluations for radiologists reading x-rays for Patients 1, 13, 20, or 21. The MSC had not collected any performance evaluations for the orthopedist who treated Patient 13, or for the podiatrist who treated Patient 1. In an interview with the Risk Manager on 7/18/08 at 11:50 a.m., the Risk Manager stated the Quality Assessment program activities were event driven. The Risk Manager provided reports for events related to transfers to an off-campus emergency room that included the occasions when Patient 1 and Patient 13 received x-ray care and consultations with nonprivileged practitioners. The reports did not measure, analyze or evaluate the quality of service provided by those practitioners. The Risk Manager could produce no other objective reflection of the services provided by the nonprivileged radiologists and consultants. Similarly, the Risk Manager could provide no objective evidence for the performance of contracted partners, specifically for Hospital A and Hospital B who had transfer agreements with the hospital. The risk manager had no process to	A 310	Individual(s) responsible: ♦ Medical Director ♦ President of the Medical Staff ♦ Regulatory Compliance officer **How Monitored:** ♦ Patient Care Contracts are reviewed for performance quality by the MEC and Board of Trustees annually. ♦ The Director of PI is responsible for collecting, analyzing & reporting monitoring evidence ♦ Data are reported *to* the Medical Staff, MEC and to the Board of Trustees no less than annually and more frequently if indicated. ♦ Copy of evidence o Vendor Evaluation Form o Quality Indicator Tracking and Trending Plan o Amendment to Transfer Agreement 2. Assessment & Referral (A&R) In August, 2008 the following actions were initiated. 1. Development of an A & R QI Indicator Tool for 100% Concurrent reviews started on September 1, 2008. 9/1/08 2. Indicators monitored weekly 9/1/08	

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A 310	Continued From page 30 directly access data from those hospitals that reflected the quality of performance for the services they provided to hospital patients, such as rates of hospital acquired infections, medication errors, preventable deaths, falls, delays in treatment, x-ray overreads, or timeliness and consistency of providing medical records. Although the hospital reported only one death in the past year, they were not able to track the outcomes for patients transferred to an acute care hospital who may die (or become disabled) subsequently at the other hospital to evaluate relationships between care here and an adverse outcome. In an interview with CEO on 7/23/08 at 6:15 p.m., CEO stated she was not aware that Patient 13 was sent to the suspended MRI vendor for a wrist MRI on 7/15/08. CEO acknowledged that patients might need open MRI services and specialty consultations that the hospital had not organized to provide, evaluate or monitor. Radiologists still had not been acquired as members of the medical staff or assigned privileges to provide radiologic services to SVH patients. Orthopedists, podiatrists and other consultants had not been credentialed and privileged by the medical staff. No system had been developed to monitor the performance of those individuals providing a medical level of care to SVH patients. 2. A&R Activities Section 3.10(q) of the Board of Trustees Bylaws, approved 11/17/06, obliged the Board to assure that all patients with the same health care problem were receiving the same level of care in the Hospital.	A 310	include: o 5150 Completed Accurately o Medical Screening Completed, o Consent for Assessment, o EMTALA Log completion, o Durable medical equipment, o Total calls entered into HMS, o Total calls with supplemental Documentation. Implementation of these corrective actions was completed on August 31, 2008. Individual(s) responsible: ♦ Director of A & R ♦ Director of Performance Improvement **How Monitored:** ♦ The A & R QI Indicator Tool will be monitored and corrected through staff education on a weekly basis by the Director of A & R and evidence of staff education ♦ The Director of Performance Improvement (DPI) will aggregate, analyze and trend the data for Medical Staff Committee(s) on a Quarterly	

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A 310	Continued From page 31 Section 2.2(d) of the Medical Staff Bylaws, approved 2/25/08, obliged the medical staff to monitor patient care practices, including intake and assessment. Section 2.2(e) further required the measurement, assessment and improvement of patient care processes and outcomes through a valid and reliable quality management program. Review of 30 A&R walk-in patients' medical records, for scheduled and unscheduled patients, in conjunction with staff interviews, determined that A&R patients were evaluated and processed contrary to A&R policies and procedures. For 27 of the 30 patients (Patients 35, 36, 37, 38, 39, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, and 63), the hospital failed to provide a qualified medical person to evaluate the patients for the presence of an emergency medical condition per Policy 900.18. For 11 unscheduled patients with emergency medical conditions (Patients 37, 39, 41, 42, 43, 46, 50, 54, 58, 60, 63), the hospital failed to provide stabilizing treatment within the capability of the hospital (Policy 900.18, 900.19). For 12 unscheduled patients with emergency medical conditions (Patients 35, 37, 39, 41, 42, 43, 46, 50, 54, 58, 60 and 63), and 6 scheduled patients with emergency medical conditions (Patients 36, 38, 47, 52, 53, 57), the hospital failed to arrange for safe transportation and appropriate transfers (Policy 900.22). The hospital failed to maintain an organized and accurate central log for emergency patients (Policy 900.24). (Refer to A 0021, A 0023, A 1079, A 1103 and A 1104) In an interview with the Risk Manager on 7/31/08 at 12:40 p.m., the Risk Manager stated the activities of the Assessment and Referral	A 310	basis. ◆ Frequency of monitoring o Quarterly ◆ Oversight of findings / compliance data or other evidence by the Director of PI and reported by Director of A & R to Quality Council. ◆ The ongoing concurrent audit tool for September, 2008 was presented in the September Quality Council Meeting. ◆ Copy of evidence o Quality Council Minutes for September, 2008 o Attached copy of A & R PI Concurrent Audit Tool 3. QAPI reviews for Other Services a. Infection Control b. Dietary On August 20, 2008, the following actions were initiated. 1. Hospital QAPI data for July, 2008 was aggregated and reported to Medical Staff and Medical Executive Committee. 2. New indicators for the Dietary Department and	9/1/08 10/1/08

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A 310	Continued From page 32 department were evaluated annually (1 year review). The A&R Director provided reports to the Quality Committee which showed 100% compliance in the selected indicators. The Risk Manager was asked to provide quality assessment documentation for the accuracy and completion of A&R activities including the ER log, completion of the A&R packet, completion of transfer forms, ensurance of safe transfers, and medical staff approval of the training method for the Qualified Medical Personnel Registered Nurse. These requested items were not produced prior to the survey exit on 8/1/08. The QAPI activities that addressed oversight of emergency services from the A&R department did not identify noncompliant practices of A&R, did not identify disparities in treatment of A&R patients compared to inpatients, did not identify the disorganized practices of A&R, and thereby could not evaluate the effectiveness of this department. 3. Other Services Section 3.10(r) of the Board of Trustees Bylaws, approved 11/17/06, obliged the Board to designate individuals or departments to evaluate and monitor quality of care in particular patient services. When there was no designated department, the Board must establish an appropriate monitoring and evaluation process. Other QAPI monitoring responsibilities outlined in the medical staff bylaws were addressed as deficient in A 0747, infection control oversight. In addition, the governing body oversight for contracted services (refer to A 0084), dietary department practices (refer to A 265) and organ, tissue and eye donation opportunities (refer to A	A 310	Infection Control program were approved. 3. Medical Staff Committee minutes reflected the aggregate data and reported information. 10/1/08 On September 16, 2008 the following actions were initiated. 1. Hospital QAPI data for August, 2008 was aggregated and reported to Medical Staff and Medical Executive Committee. 9/30/08 2. Medical Staff Committee minutes reflect the aggregate data and reported information. 9/30/08 3. A new format and updated indicators for reporting concurrent PI departmental clinical indicators was implemented on Oct 1, 2008. Departments included: 10/1/08 a. A & R, b. Infection Control, c. Pharmacy, d. Dietary c. Organ Procurement Individual(s) responsible: ◆ Director of A & R, ICP, Pharmacy, Dietary and the DON ◆ Director of Performance Improvement On September 24, 2008, the	

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	Continued From page 33		following actions were initiated on organ procurement. 1. Meeting with the Director of Golden State Donor Service to: a. Review and revised the Organ Procurement Policy. b. Establish a Definition for "Imminent Death" c. Complete an annual Review of the death; d. Establish a Staff Training schedule; e. Obtain signatures on final policy approval. 2. The Organ Procurement policy was reviewed and amended to meet the intent of the contract agreement for organ, tissue and eye procurement between Sierra Vista Hospital and DCI Donor Services, Inc., d/b/a Sierra Eye and Tissue Donor Services (SETDS)/Golden State Donor Services and to include a definition for "imminent death." Signature approval by the Golden State Donor Services and the CEO was completed. 3. An annual review of the single death occurring in 2008 was done. It was	9/24/08 9/24/08 9/24/08

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	Continued From page 33A		concluded that the death of patient 1 could not be declared at SVH as resuscitation was still in progress and the patient's condition did not meet the agreed upon definition of "imminent death". 4. Training of SVH staff was completed on 9/30/08 conducted by the Golden State Donor Services representative. All future training on OPO will be conducted by the Director of Nursing or designee. Individual(s) responsible: ◆ DON ◆ Director of Performance Improvement **How Monitored:** ◆ The Director of PI is responsible for collecting, analyzing & reporting monitoring evidence ◆ Data will be reported to the Medical Staff, MEC and to the Board of Trustees no less than annually and more frequently if indicated.	9/30/08 10/6/08

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	Continued From page 33B		concluded that the death of patient 1 could not be declared at SVH as resuscitation was still in progress and the patient's condition did not meet the agreed upon definition of "imminent death". 4. Training of SVH staff was completed on 9/30/08 conducted by the Golden State Donor Services representative. All future training on OPO will be conducted by the Director of Nursing or designee. Individual(s) responsible: ◆ DON ◆ Director of Performance Improvement **How Monitored:** ◆ The Director of PI is responsible for collecting, analyzing & reporting monitoring evidence ◆ Data will be reported to the Medical Staff, MEC and to the Board of Trustees no less than annually and more frequently if indicated. Evidence: Copy of minutes of 9/24/08	9/30/08 10/6/08

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A 310	Continued From page 33 0886) were not effectively accomplished either.	A 310		
A 316	482.21(e)(4) EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring that adequate resources are allocated for reducing risk to patients. This STANDARD is not met as evidenced by: Based on interview, policy and document review, the hospital failed to ensure that the medical staff and administrative officials were responsible and accountable for ensuring that adequate resources were allocated for reducing the risk of patients developing a hospital acquired infection. There was no documentation showing that the Infection Control Practitioner (ICP) who worked six to eight hours a week had implemented an active infection control surveillance and prevention program. Findings: On 7/15/08 at 10 a.m., a request was made to review the hospital's infection control plan. During an interview on 7/15/08 at 3 p.m., administrative staff stated that they did not have a copy of the hospital's infection control plan. Administrative staff stated that the ICP worked on	A 316	**482.21(e)(4) Executive Responsibilities** Sierra Vista Hospital now ensures that the medical staff and administrative officials are responsible for ensuring an active Infection Control surveillance and prevention program. 1. On August On 8/18/08, a full-time RN was designated infection Preventionist. 9/23/08 2. The Infection Control (IC) program was reviewed and revised on 08/26/08. (attached 1600.1; IC plan update) 9/23/08 3. The Infection Preventionist attended the Fundamentals of Infection Surveillance, Prevention and Control given by APIC on 08/11-08/14/08. 9/23/08 4. The Infection Preventionist is a current member of APIC.(see attached resume, training certificate) 9/23/08 On September 23, 2008, the following actions were initiated. 5. Infection Control Quality Indicators identified as follows: 9/23/08 a. PPD testing,	

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A 316	Continued From page 34 weekends, had a "virtual office," and that the hospital did not have copies of her policies or patient health records. During an interview on 7/15/08 at 12:10 p.m., the Director of Human Resources stated that from 1/01/08 to 7/15/08, the ICP had worked a total of 168 hours (an average of 5.85 hours a week). The Director of Human Resources stated that the ICP worked either Saturday or Sunday depending on her other work schedule. During an interview on 7/16/08 at 5 p.m., administrative staff stated that they were aware that the ICP kept the hospital's infection control manual and reports of patient infections in her "virtual office" and that those reports were not readily available at the hospital. Administrative staff also stated the ICP was a part time position and that they were not aware that the allocated infection control hours were insufficient. A review of the ICP job description disclosed that the ICP was a part time position and that the individual was responsible for preparing and submitting a monthly report to the hospital about infection control issues. On 7/16/08 at 12:35 p.m., the ICP was interviewed. The ICP confirmed that she kept the infection control manual, the patient health records in her "virtual office," and that those records were not available to administrative or hospital staff unless they requested them. The ICP stated that she was not aware that she was to submit a monthly infection control report to the hospital. The ICP stated that she had not received a performance evaluation from the hospital after 11/13/03.	A 316	b. Flu c. Hepatitis B monitoring for staff, d. Hepatitis C monitoring for patients e. Hand Hygiene. Individual(s) responsible: ◆ Infection Preventionist ◆ Director of PI ◆ Regulatory Compliance Officer **How Monitored:** • All indicators will be monitored and collected monthly with quarterly reporting • Oversight of findings / compliance data or other evidence by: All data will be reported to Director of PI for aggregate and trending purposes and the results reported to the Quality Council. • Dates already reported and to Infection Control Committee: Infection Control Manual revised and presented to Quality Council on September 16, 2008. • Copy of evidence o Position description: ADON/Infection Preventionist o P & P 1600.1, Infection Control Program	

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	Continued From page 35		○ Infection Control Plan/Program Update ○ Training Certificate ○ Resume of Infection Preventionist ○ September 16, 2008 P&T Committee and Quality Council Minutes	

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A 316	Continued From page 35 The hospital could provide no evidence or documentation showing that the hospital's medical staff or governing body was aware, responsible or accountable for allocating adequate resources to ensure the hospital had an active surveillance and infection control program.	A 316		
A 338	482.22 MEDICAL STAFF The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of care provided to patients by the hospital. This CONDITION is not met as evidenced by: Based on observation, staff interviews, medical record and document reviews, the hospital failed to have an organized medical staff that operated under its bylaws and that was responsible for the quality of care provided to patients by the hospital as evidenced by: A. The Medical Staff failed to enforce its Rules and Regulations as required by its Bylaws related to the requirement for a Qualified Medical Personnel Registered Nurse to be accurately trained and operate under standardized procedures in accordance with State law [cross reference A 0023, A 0353]; B. The Medical Staff failed to evaluate the qualifications and performance of physicians providing a medical level of care to hospital patients at off-campus locations [cross reference A 0355]; C. The Medical Staff failed to provide direct	A 338	**482.22 MEDICAL STAFF** Sierra Vista Hospital now ensures that the Medical Staff operates under its bylaws and is responsible for the quality of care provided to all patients. In July, 2008, the following actions were initiated. 1. Development of a standardized procedure for the performance of Medical Screening Exams — 9/30/08 2. Training of RNs in accordance with the standardized procedure; training conducted by physicians and QMP RN Trainer — 9/30/08 3. Monitoring of competency by a physician or a qualified QMP RN via proctoring in the performance of Medical Screening Exams — 9/30/08 4. Oversight of RN performance of Medical Screening Exams by SVH designated members of the SVH medical staff — 9/30/08 5. Approval of the standardized procedure and creation of an Interdisciplinary Practices Committee by the Medical Policy Committee of the SVH medical	

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	Continued From page 36		staff on 9/24/08. 6. Approval of the standardized procedure and creation of an Interdisciplinary Practices Committee by the MEC and Board of Trustees on 9/30/08. Individual(s) responsible: ◆ Medical Director ◆ President of the Medical Staff ◆ DON-QMP RN Trainer ◆ Regulatory Compliance Officer **How Monitored:** ◆ Method of monitoring is via 100% audit of MSE documentation for completeness, accuracy, and adherence to the standardized procedure. Variances are addressed via remedial education. ◆ The QMP RM Trainer - DON is accountable for oversight of the monitoring process Frequency of monitoring is daily with oversight of findings / compliance data or other evidence by the Interdisciplinary Practices Committee, with reports to the MEC and Board of Trustees. ◆ Evidence: o Medical staff Minutes documenting approval via the Medical Policy	9/30/08

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	Continued From page 360A		Committee on 9/24/08, and MEC 9/30/08 o Copy of SVH policy 900.40 o and 900.41 attached. On 10/1/2008, the following actions were initiated: 1. A contractor evaluation form has been adopted for consistent and systematic data collection. 2. Quality Indicators have been derived from the form and a tracking and trending process established. 3. An oversight committee was created by the SVH Medical Director to review quality of care and performance data on all patient care contractors. Members include SVH medical staff, the SVH Regulatory Compliance Officer, and vendor representatives. This committee reports to the Medical staff and MEC and through them to the Board of Trustees no less than annually. 4. A Transfer Agreement amendment was finalized on 9/25/2008 for both local hospitals contracted with the Hospital that specifically provides for sharing of information for the purposes of evaluating the quality of care provided to SVH patients at off-campus locations. • This Amendment has been	10/2/08 10/2/08 10/2/08 10/2/08

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	Continued From page 36B		reviewed by Methodist Hospital and Kaiser Foundation Hospital South legal departments and has been approved.	
			5. A new Service Agreement was written for a local outpatient diagnostic clinical radiology service. This document defines the medical staff quality oversight of this service.	10/3/08
			6. Radiologists will maintain Hospital medical staff privileges as consultant members.	10/3/08
			7. A second agreement for on-site radiology services is in process.	10/6/08
			Individual(s) responsible: ◆ Medical Director ◆ President of the Medical Staff ◆ Regulatory Compliance Officer	
			How Monitored: ◆ Patient Care Contractors are reviewed for performance quality by the MEC and Board of Trustees annually. ◆ The Director of PI is responsible for collecting, analyzing & reporting monitoring evidence ◆ Reports will be made to the Medical Staff, MEC and through them to the Board of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054087	A. BUILDING _____ B. WING _____	08/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA VISTA HOSPITAL, INC	8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Continued From page 36C		Trustees no less than annually and more frequently if indicated. ◆ Copy of evidence o Vendor Evaluation Form o Quality Indicator Tracking and Trending Plan o Amendment to Transfer Agreement In July, 2008, the following actions were initiated. 1. Development of a standardized procedure for the performance of Medical Screening Exams 2. Training of RNs in accordance with the standardized procedure; training conducted by physicians and QMP RN Trainer 3. Monitoring of competency by a physician or a qualified QMP RN via proctoring in the performance of Medical Screening Exams 4. Oversight of RN performance of Medical Screening Exams by SVH designated members of the SVH medical staff 5. Approval of the standardized procedure and creation of an Interdisciplinary Practices Committee by the Medical Policy Committee of the SVH medical staff on 9/24/08.	9/30/08 9/30/08 9/30/08 9/30/08 9/30/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Continued From page 36D		6. Approval of the standardized procedure and creation of an Interdisciplinary Practices Committee by the MEC and Board of Trustees on 9/30/08. Individual(s) responsible: ◆ Medical Director ◆ President of the Medical Staff ◆ DON-QMP RN Trainer **How Monitored:** ◆ Method of monitoring is via 100% audit of MSE documentation for completeness, accuracy, and adherence to the standardized procedure. Variances are addressed via remedial education. ◆ The DON-RN QMP Trainer is accountable for oversight of the monitoring process ◆ Frequency of monitoring is daily ◆ Oversight of findings / compliance data or other evidence is by the Interdisciplinary Practices Committee, with reports to the MEC and Board of Trustees. ◆ Minutes documenting medical staff approval via the Medical Policy Committee on 9/24/08, and MEC 9/30/08	9/30/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Continued From page 3 of 5		◆ Copy of SVH policy 900.40 and 900.41 attached. On 9/16/08, the following actions were initiated. 1. The revised Infection Control Plan, policy and procedures manual was presented to the Medical Staff Committee on 09/16/08. 2. The revised Infection Control plan, policy and procedures manual was presented to the MEC on 9/17/08 and forwarded to the Board of Trustees on 9/30/08. (see attached IC Policy and Procedure Table of Contents) 3. Infection Preventionist reported data in Medical Staff Committee responsible for Infection Control on August 19, and September 16, 2008. 4. The Infection Control report was forwarded to the MEC on 09/17/08 and to the Board of Trustees on 9/30/08 (see attached 1600.8, HAI Surveillance Report 2008, Antibiotic usage) 5. Infection Control Program annual evaluation has been done on the IC program was presented to Medical Staff committee responsible for Infection Control function on 9/30/08. Individual(s) responsible: ◆ Medical Director	9/30/08 9/30/08 9/30/08 9/30/08 9/30/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Continued From page 36F		♦ Regulatory Compliance Officer ♦ Infection Preventionist How Monitored: ♦ Method of monitoring: see IC monitoring indicators: hand-washing compliance, PPD compliance, Flu immunizations, and Hepatitis C vaccinations. Reports required for SB739 compliance showing employee and inpatient participation in vaccination programs. A compliance report is made at each MEC and Board of Trustees meetings beginning 9/30/08. ♦ Frequency of monitoring: ongoing monthly and quarterly ♦ Oversight of findings / compliance data or other evidence by the medical staff committee responsible for Infection Control and MEC ♦ Dates already reported and to the medical staff committee responsible for Infection Control 9/16/08 and to MEC 9/17/08. ♦ Copy of evidence: Minutes of 8/19/08, 9/16/08, 9/17/08, and 9/30/08. ♦ Annual evaluation of Infection Control Program.	