PRINTED: 09/19/2008 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ILDING	COMPLETED	
		054087	B. WIN	NG	08/	01/2008
	PROVIDER OR SUPPLIER	c		STREET ADDRESS, CITY, STATE, ZIP COL 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
A 000			A C	000		
	Department of Pub	cts the findings of the California lic Health during a full llowing a complaint validation				
	meet the criteria of	the hospital was determined to a dedicated emergency per definitions at 42 CFR				
	Representing the [Department:				
	Alina Davis RN, 173 Deidre Sakauye RN Denise Howell, RN, Letitia Creighton, R Esther Cistone MD, John Christensen, F Francia Trout, Medi Dagma Bender-Por	I, 20435 17071 N, 16501 22710 Pharmacist, 15338 cal Records, 11389				
		(35 inpatients, 30 walk-in cheduled Admission and nt outpatients, 1				
	CEO=Chief Executive DSD = Director of S EMC= emergency m	ors ography (a diagnostic test) ve Officer taff Development nedical condition ncy Medical Treatment and				
1		EDICHARDHED DERDESENTATIVE'S SIGNA		TITLE		(YE) DATE

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.

Event ID: J66R11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE COMF	SURVEY PLETED
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l	PROVIDER OR SUPPLIER	c	,	STREET ADDRESS, CITY, STATE, ZIP C 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
A 000	GACH = General A ICP-Infection Contr LCSW = Licensed (I&O, I/O = Intake ar LN=Licensed Nurse MAR= Medication A MD = Medical Doctr MFT = Marriage an MHT = Mental Heal MRI=Magnetic Rese test) MSE = Medical Scre MSW = Masters of S P&P = Policy and Pr	cute Care Hospital of Practitioner Clinical Social Worker as Output e Administration Record or d Family Therapist th Technician onance Imaging (a diagnostic eening Examination Social Worker rocedure edical Person or Personnel etitician urse sta Hospital	A 00			
	EMTALA/OBRA/CO EMTALA 482.11(c) LICENSUITH The hospital must as licensed or meet oth are required by State This STANDARD is Based on staff interviducument reviews, that personnel met a by State or local laws	not met as evidenced by: iews, medical record and ne hospital failed to assure pplicable standards required s. The hospital failed to ormed MSEs in A&R based	A 023	482.11(c.) LICENSURI PERSONNEL Sierra Vista Hospital now ethat it provides a Medical Exam (MSE) by a Qualified Personnel (QMP) for anyon presents for an unschedule 1. 900.40 Standardized for Qualified Medical Personnel-Registered was created to define standardized procedur in accordance with the	ensures Screening Medical e who ed visit. Procedure Nurses the es for QMP	9/30/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	COMP	PLETED
1		054087	B. WING	G	08	/01/2008
	PROVIDER OR SUPPLIER	ıc		STREET ADDRESS, CITY, STATE, ZIP COD 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Findings: The hospital Medic (approved on 3/19/addition to physicial practitioners are gr scope of the clinical which they have be medical screening specified QMP medical screening Regulation, Section Practice of Nursing (c) "Standardized psection, means: (1) developed by a head Chapter 2 (commer Division 2 of the He collaboration among professionals included The policies and proguidelines for stand Division of Licensing California and the Binay jointly promulgate administered by the (BRN). California Code of Figure 14. Board of Register Article 7. Standardized proguers of this (a) "Standardized price in the standardized price in the	al Staff Rules and Regulations 08) indicated in Section 21: "In ns, the following classes of anted authority, within the I privileges or prerogatives for en approved, to conduct examinations: RN's with dical screening training." and Professions Code, Article 2. Scope of 2725, Legislative intent, rocedures," as used in this Policies and protocols Ith facility licensed pursuant to noing with Section 1250) of alth and Safety Code through administrators and health ing physicians and nurses. Stocols shall be subject to any ardized procedures that the gof the Medical Board of oard of Registered Nursing ate (make known to the proclaim; cause to come d, the guidelines shall be Board of Registered Nursing ed Procedure Guidelines. tions	A 02	the Nurse Practice Act, a BRN Guidelines for Stand Procedures; final approve 9/30/2008. 2. 900.41 Interdisciplinary Practices Committee wa approved to provide over standardized procedure functions. 3. The competency process QMP in accordance with Standardized Procedures place. 4. The hospital will underta comprehensive evaluatio patient population served has identified potential emergency care scenario which assessment, policic procedures, training and competencies have been developed to enable it to safe and adequate initial treatment of an emergen Individual(s) responsible: Medical Director COO Director of Nursing Regulatory Compliance How Monitored: Method of monitoring emergency procedures include monthly collect performance data on q indicators including	ardized al y as rsight for for the is in ke a n of the d and s, for es, provide cy. Officer will tion of	9/30/08 10/1/08 10/31/08

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE COMP	SURVEY LETED
		054087	B. WIN	G	08/	01/2008
	PROVIDER OR SUPPLIER VISTA HOSPITAL, IN	c		STREET ADDRESS, CITY, STATE, ZIP CO 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Professions Code Sare to be performed procedures"; Section 1472. Stand An organized health standardized procedure functions perform standardized under the conditions system's standardized under the conditions system's standardized provide the system the nurse meets its education requiremed functions. Section 1474. Standardized provide in the standardized provide in the system of the system o	Section 2725(c) and (d) which according to "standardized dardized Procedure Functions of care system must develop dures before permitting operform standardized at A registered nurse may ed procedure functions only as specified in a health care ed procedures; and must with satisfactory evidence that experience, training, and/or ents to perform such lardized Procedure Guidelines andardized procedure mulgated by the Medical and by the Board of seedures shall include a fithe method used in oving them and any revision ed procedure shall: ed and signed by the e system personnel e it. Indardized procedure murses may perform and ances. It is requirements which are to ered nurses in performing ed procedure functions. In rience, training, and/or ents for performance of	A 02	documentation on locompleteness of documentation for a assessments, and appropriateness of dispositions. Data we collected monthly arreported quarterly. The Director of Performance (DPI) was a manageregate, analyze at the data and present Hospital Quality Coundedical Staff, Medical Staff,	ill be and bring and trend to the and a a records atment of the armined by conitored all fithe tor of all. The all are all all all all all all all all all al	

	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	` ´	ULTIPLE CO LDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
J		054087	B. Wif	IG		08/	01/2008
]	F PROVIDER OR SUPPLIER A VISTA HOSPITAL, IN	c	•	8001 BR	DDRESS, CITY, STATE, ZIP CODE UCEVILLE ROAD MENTO, CA 95823		
(X4) IE PREFI TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH ROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 02	nurses authorized to procedure functions (6) Provide for a me record of those pers standardized proced (7) Specify the scorperformance of star for example, immediately physician. (8) Set forth any spewhich the registered communicate with a concerning the patie (9) State the limitatic which standardized performed. (10) Specify patient (11) Provide for a method the standardized procedured performing MSEs. To screening examination reach, with reason point at which it can emergency medical exist. The Medical Security Medical Security Medical Security Medical Empsychiatric emergency indicated to documer provided to stabilize the presenting with EMC	perform standardized sethod of maintaining a written sons authorized to perform dure functions. See of supervision required for indardized procedure functions, liate supervision by a secialized circumstances under a nurse is to immediately expatient's physician ent's condition. Sons on settings, if any, in procedure functions may be record keeping requirements. Sethod of periodic review of occdures. In the Director of the presented a 2-page P&P dical Screening Exam" as a sure used by the RN's when the P&P defined a medical on as, "the process required thable clinical confidence, the be determined whether an condition does or does not creen shall be completed by the facility for assessment." a list of life-threatening and the regencies, a list of acute cies and pain scale and that any medical treatment the condition for patients	A	23			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		054087	B. Wif	NG _		08,	/01/2008
•	PROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	"Medical Screening standardized proced P&P did not contain standardized proced On 7/22/08 at 1 p.m Outpatient Services EMTALA training, we the facility, performed patients presenting seeking treatment for conditions in the A&The Outpatient Services 2-page test and evaluest key (containing questions). The test medical presentation should take (call 911 home) but did not remedical screening excomplaints and sympmedical condition was monitoring was part or the capabilities of emergency medical scresult of a medical scresult of a medical screening excomplaints and sympmedical condition was monitoring was part or the capabilities of emergency medical scresult of a medical screening of a medical screeni	Examination," as fulfilling the dure for the QMP RNs, yet the the eleven elements of a dure described by State law. . the Director of the stated that RNs with hich was provided by her at do MSEs for all walk-in to the facility potentially or emergency medical R department. The Director of ces stated that she evaluated for MSE by administering a duated the results by using a the answers to the contained questions about an and what action the QMP, call MD, send patient flect the elements of a stam, the focus on identified botoms, how an emergency as defined, how ongoing of a medical screening exam, the hospital to respond to conditions identified as a creening exam. In short, the ect competence of a trained	AC	023			
A 043	482.12 GOVERNING The hospital must ha	ve an effective governing	A 04	3			
	Dody legally responsi	ble for the conduct of the					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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	PROVIDER OR SUPPLIER	C	s	TREET ADDRESS, CITY, STATE, ZIP CO 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823	DE	
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	hospital as an instituthave an organized of legally responsible in must carry out the final pertain to the grand of that pertain to the grand of the contractor and document to have an effective responsible for the constitution as evidential. A. To ensure that the bylaws, rules and possible for the constitution as evidentially assessment and compliance and consultation services physician orders. [cr. 0338, A 0353, A 110] B. To ensure that the accountable to the ground consultation services and compliance and contractors are for hospital preference A 0049, A. C. To ensure that consultation a safe at that contractors proving the contractors proving the contractors are contractors and comply with participation. [cross in the contractors are contractors and comply with participation. [cross in the contractors are contractors and comply with participation. [cross in the contractors are contractors are contractors and contractors are contractors are contractors and contractors are contractors are contractors are contractors are contractors.	ution. If a hospital does not governing body, the persons or the conduct of the hospital unctions specified in this part overning body. Is not met as evidenced by: on, staff interviews, medical not reviews, the hospital failed governing body legally conduct of the hospital as an oced by the following failures: It medical staff enforced its elicities relating to Qualified who perform medical fection control oversight, and performance es oversight, emergency ence with EMTALA initialing and privileging y services and off-campus and timely completion of coss reference A 0049, A 4, A 1112] The medical staff was overning body for the quality attents in all locations. [cross 0338, and A 747] The intracted services were and effective manner and ided services that permit the th all Conditions of	A 04	Sierra Vista Hospital ensure medical staff bylaws, rules policies related to Qualified Personnel who perform med screening exams are enforced in July, 2008, the following were initiated. 1. Development of a standardized proced the performance of Screening Exams 2. Training of RNs in accordance with the standardized proced training conducted physicians and QMP Trainer 3. Monitoring of comp by a physician or a conformance of Med Screening Exams 4. Oversight of RN performance of Medical Screening Exams 4. Oversight of RN performance of Medical Screening Exams 5. Approval of the standardized procedure and creat linterdisciplinary Pracommittee by the Medical staff on 9/2 medical staff on 9/2	s that the and defical dical d	7/30/08 9/24/08 8/1/08 and ongoing 8/1/08 and ongoing 9/30/08

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	IULTIPLE CO	NSTRUCTION	(X3) DATE COMP	
		054087	B. WI	vg		08/	01/2008
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	Continued From pa	ge 1		Impl action Indiv • • • • Hov	6. Approval of the star procedure and cre Interdisciplinary Procedure and cre Interdisciplinary Procedure and of Trustees (9/30/08). Idementation of these cons was completed on widual(s) accountable: Medical Director President of the Medical of MSE documentation for completeness, accural adherence to the star procedure. Variance addressed via remedical procedure. Frequency of monitodaily Oversight of findings compliance data or devidence by the Interdisciplinary Prace Committee, with repting the MEC and Board of Trustees. Medical staff approvaled and MEC 9/100 of SVH policy 9000 copy of SVH policy 9000 copy of SVH policy 9000 committees and MEC 9/100 copy of SVH policy 9000 committees and MEC 9/100 copy of SVH policy 9000 committees and MEC 9/100 copy of SVH policy 9000 copy of	eation of an ractices MEC and on sorrective 9/30/08. dical Staff face Officer ag is via racy, and fandardized es are dial foring is foother corts to of fall via the face on /30/08	9/30/08

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED 08/01/2008	
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,	PROVIDER OR SUPPLIER VISTA HOSPITAL, IP			TREET ADDRESS, CITY, STATE, ZIP 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823		101/2000	
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	Continued From page 2	age 1A		Sierra Vista Hospital pro oversight for the Infecti Program through the me The Governing Body, the Medical Executive Comminitiated the following a 8/11/2008: An evaluation of Infection Control was completed i external Best Pr expert on 9/8/- 9/12/08. Based or evaluati Medical compreh revised to Control of Policies Procedur were ap	ion Control edical staff. rough the nittee, actions on If the ol Program by an actices 08 through In the on, the Staff Inensively the Infection Program and res; these proved by ical Staff on and I data were I medical I medi	9/30/08 9/30/08 and ongoing	



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET ADDRESS, CITY, STATE, ZIF 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823		01/2008	
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	Continued From p	age 1B		 The report of the evaluation was medical staff or the Governing requires Medical reporting of Inflass part of its stagenda. Individual(s) responsible Regulatory Compound Medical Director Infection Prevent Method of monitor Control will including Test and the program for inpart employees, flu via program effective quarterly reports medical staff and Trustees. Data will be colled and reported quand Oversight will be the medical staff committee(s) resinfection control, performance impound MEC and the Boar Trustees. Reports required in Reported quarded. 	made to the n 9/30/08. Body now al Staff fection Control anding e: liance Officer tionist pring Infection and monthly formance andicators being of accination tients and depatitis Ceness and to the SVH d Board of cted monthly arterly. provided by ponsible for rovement, and of	9/30/0	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	MULTIPLE CONSTRUCTION ILDING	(X3) DATE COMP	SURVEY
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	PROVIDER OR SUPPLIER	c	•	STREET ADDRESS, CITY, STATE, Z 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823	PIP CODE	
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	Continued From pa	ge Z		committees res infection contro	ase Program and and and me medical staff aponsible for ol and QAPI, to bard of Trustees ADPH beginning on Control and 9/17/08. In Control ation presented and 9/30/08. Ital Governing at services after acute care ective, of the services. Itowing actions ation form has consistent and allection. have been orm and a aing process ation form has	10/1/08 10/1/08 10/1/08

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILDING			(X3) DATE SURVEY COMPLETED	
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, , , , , , , , , , , , , , , , , , , ,	PROVIDER OR SUPPLIER	c		8001 B	NODRESS, CITY, STATE, ZIP CODE RUCEVILLE ROAD AMENTO, CA 95823			
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	Continued From pa	ge 1)		6.	patient care contractors. Members include SVH me staff, the SVH Regulatory Compliance Officer, and representatives. This con reports to the Medical sta MEC and through them to Board of Trustees no less annually. A Transfer Agreement amendment was finalized 9/25/2008 for both local hospitals contracted with Hospital. This Amendment has reviewed by Methodi Hospital and Kaiser Foundation Hospital legal departments ar been approved. A new Service Agreement written for a local outpat diagnostic clinical radiolo service. This new agreem specifies roles and responsibilities of each	vendor nmittee aff and the than I on the been ist South and has was ient gy	9/25/08	
					organization for the care a supervision of the patient the time of the hospital physician order to the reta the patient. This docume defines the quality oversig this service.	from urn of nt also		
					Radiologists will maintain Hospital medical staff priv as consultant members.	rileges	10/3/08	

FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I	MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,		054087	B. WI		-)/01/2008
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823		V01/20 08
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	Continued From pa	ge Æ		8. A second agreement radiology services is Individual(s) responsible CEO Medical Director President of the Med Regulatory Compliant How Monitored: Patient Care Cont reviewed for perfequality by the MED of Trustees annual The Director of Pleresponsible for containing evident analyzing & report monitoring evident reviewed Staff, MED through them to the Trustees no less the Sierra Vista Hospital now compliance with the requester services. Sierra Vista Hospital now compliance with the requester services. The facility now ensure services available to units are integrated in Assessment and Reference such that patients previous the mergency concreceive stabilizing interestment with the containing the hospital and equitations.	dical Staff face Officer racts are formance C and Board fally. is bllecting, ting face add to the C and fan annually of ensures uirements of fin of face for the face for th	9/1/08

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	PROVIDER OR SUPPLIER	oc .		STREET ADDRESS, CITY, ST 8001 BRUCEVILLE ROA SACRAMENTO, CA 9	D .		
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	Continued From pa	ige 1/F		All paties unsched who are emerger condition stabilizing the capathospital. Clinical. Clinical. Screening Assessmand Screening Emerger amended guideline and function physicial oversee supervisity based on needs. Sierra Vistensures to solely relemble emergendoes provappraisal treatment hospital. Capacity. 2. Sierra Vista Hottimely and efficommunication hospital and of the communication whospital and of the communication hospital and of the communication hospital and of the communication whospital and of the communication hospital and of the communication ho	Services Policies, Emergency og and Initial ent, 900.20 Medical og Exam and 900.22 ocy Care were d to include clear es for the role(s) ction(s) of the on and RN QMP to and provide ion and stabilization of assessed patient ta Hospital now chat it does not ly on 911 cy services, and vide initial on and stabilizing on within the on capability and cospital now ensures fective on between the	10/1/08	

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		054087	B. W!	NG		08	3/01/2008
	PROVIDER OR SUPPLIER VISTA HOSPITAL, IN	c		800	ET ADDRESS, CITY, STATE, ZIP COI 1 BRUCEVILLE ROAD CRAMENTO, CA 95823	DE	
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	Continued From pa	ge 7G			to provide care under a agreement. The hospital's tagreement has amended and requires comple contracted hospital requires assure docume received. Sierra Vista Hospital not that emergency policies procedures are followed hospital staff. RN's working in Assessment and department (A deducated regard appropriate man of patients prese with an EMC as in Policies 1000 Major Medical Emergency Treat and 900.22 the Emergency Care Training include appropriate utiling emergency equipand calling a Contract of the c	transfer to been now liance by spitals. audited to entation is wensures to and deby the Referral to R) were ding the nagement tenting defined 0.13 attment codization of pment de Blue. wensures	9/30/08 8/1/08 and
					supervised by a qualified member of the medical	d staff.	onogoing
	_			5	. Sierra Vista Hospital nov	v ensures -	9/30/08

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY 8001 BRUCEVILLE I SACRAMENTO, C	ROAD		
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	Continued From page 2	age /		screening stabilizing with emer conditions and funct with state Individual(s) r Medical Directo Directo Regulat How Monito The A 8 which e comple Screen stabiliz and aut form (if monitor by the l Identifi correct educati disciplii The Dire and Ref of all At Transfe 100% of comple docume	esponsible: I Director r of Nursing r of Assessment and Referral ory Compliance Officer		

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	AULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER SIERRA VISTA HOSPITAL, INC SIERRA VISTA HOSPITAL, INC SACRAMENTO, CA 95823							
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	Continued From par	96 17		log and 100% assessments for documentation and emergence procedures in hospital policit procedures. • A sample of more reflecting initities persons who at to have an emergence weekly by the Director, memerged Medical Staff, Nursing and Dial Assessment & Deficiencies and addressed and tracked, trend and used to improcesses. • The Director of Improvement (aggregate, and the data and person to the data and pers	nonitored via by the A&R e incident report of face to face or adequate n of stabilization y care accordance with es and nedical records ial treatment of re determined ergency now monitored Medical abers of the Director of rector of Referral. re immediately results are ed, analyzed aprove clinical f Performance DPI) will alyze and trend resent it to MEC and BOT on sis. tracking and or September, ented in the ality Council		

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	Continued From pa	ge 1 <u>J</u>		The medical direct the physician onto assure that 24 is provided. Any supervision issue are reported to the Administrator on the Medical Direct resolution. Sierra Vista Hospital ensuredical staff credential privileges providers of reservices and off-campus services.	call schedule /7 coverage medical s that arise he Call and to ctor for sures that the s and adiology	10/3/08
				On 9/23/2008 the follow were initiated. An application of staff membership privileges is in pradiologist who will the quality of cast by a mobile radiology organication accuration accuration accuration and will report expenses the following staff with radiologists were by the medical specific staff with radiologists will own quality of care puther mobile radiological and will report expenses.	for medical ip & rocess for a will oversee are provided ology service Joint redited zation. ileges for e approved taff on medical ogy versee the rovided by logy service	10/6/08

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FORM APPROVED OMB NO. 0938-0391

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	Continued From pa	ge /M		of Trustees a The Director of responsible for analyzing & responsible for the control command 9/30/08 Minutes of Que 9/16/08 and 9/30/15	es no less than sible: re Medical Staff pliance officer Contracts are performance e MEC and Board nnually. of PI is or collecting, reporting vidence reted to the formula to the stees no less than more frequently 18, 900.20, 10, 900.40, 113 e P&T/Infection nittee 9/16/08 reality Council 19/30/08 10 (20,17/08 and	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING 054087 (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMF	(X3) DATE SURVEY COMPLETED			
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	emergency services which resulted in a large construction, control, and communicable 0747, A 0749, A 075 F. To develop, imple effective, ongoing, handled assessment improvement progradepartments and seservices furnished user arrangement). [cross A 0267, and A 0310] The cumulative effective statutorily mandated Governing Body. 482.12(a)(5) MEDIC ACCOUNTABILITY [The governing body medical staff is accobody for the quality of the statutorily of the statutorily mandated Governing Body. 482.12(a)(5) MEDIC ACCOUNTABILITY [The governing body medical staff is accobody for the quality of the statutorily mandated for the statutorily mandated Governing Body. 482.12(a)(5) MEDIC ACCOUNTABILITY [The governing body medical staff is accobody for the quality of the statutorily mandated for the statutorily mandated Governing Body. 482.12(a)(5) MEDIC ACCOUNTABILITY [The governing body medical staff is accobody for the quality of the statutorily mandated for the statutorily mandated Governing Body. 482.12(a)(5) MEDIC ACCOUNTABILITY [The governing body medical staff is accobody for the quality of the statutorily mandated for the statutorily mandated Governing Body. 482.12(a)(5) MEDIC ACCOUNTABILITY	s and EMTALA requirements concurrent EMTALA survey. 2092, A 1100] tive program for the and investigation of infections diseases. [cross reference A 50, and A 0756] ement, and maintain an appropriately wide, data-driven and performance are that involved all hospital rvices (including those nder contract or a reference A 0263, A 0265, a contract or a reference A 0263, A 0265, a contract or a reference A 0263, a 0265, a contract or a reference A 0	A 04	482 12(5)(5) MEDICAL	chat care embers of the evaluated. medical lowing eement ocal tic clinical This new	10/3/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ensure that the medithe quality of care providenced by: 1) the medical staff of care to be deliver specialists who were staff and were not providenced by: 1) the medical staff of care to be deliver specialists who were staff and were not providenced by: 2) the medical staff of control activities as a bylaws; 3) the medical staff of control activities as a bylaws; 3) the medical staff of federal laws by permoversight and supernservices. 4) the medical staff of federal laws by permoverservices are medical screening their licensure. Findings: Outlined in Article VII Bylaws, approved on requirements for the activities that contributing provement of the contributions.	the governing body failed to dical staff was accountable for provided to patients as arranged for a medical level and the end members of the medical rivileged by the hospital to ces; the medical staff failed to be softhose nonprivileged boort to the Board; failed to monitor infection required by the medical staff failed to provide quality vision for emergency are failed to comply with state and notiting registered nurses to be ening exams to rule out conditions without the ardized procedure, and cal staff to perform portions and exam beyond the scope of	AC	2. 3. 4.	and responsibilities of organization for the casupervision of the patifrom the time of the high physician order to the of the patient. This document also defines quality oversight of this service. Radiologists will maint Hospital medical staff privileges as consultan members. A second agreement for site radiology services process. Delineated privileges for radiologists were appropriately the medical staff or 9/30/08. Members of the medical staff or 9/30/08. Members of the medical staff with radiology privileges will oversee quality of care provided the mobile radiology seand will report evaluate the quality of care provided the medical staff and Board of Trustees quark Mobile radiology service provided on order. Patients	are and ent ospital return the is ain t or on- is in or oved of the down of vided and the terly. es are ients	10/3/08 10/6/08 9/30/08 10/3/08
		ctive mechanisms to monitor dity of patient care and the			requiring emergency m	icuical	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE : COMPL	
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	clinical performance clinical privileges w 8.3(b) Ongoing revior patient care prace process of overall of improvement; 8.3(c) Delineation of Staff members are sponsibilities to of consistent with individemonstrated ability 8.3(g) Reviewing the providers who are no privilege delineation governing body of ficare providers. The Medical Staff Bestated in Section 2.2 accountable to the Eprocesses and outcome Members authorize Medical staff members authorize Medical staff members authorize Medical staff members authorize Medical staff members authorize Members who has Clathat responsibility." to abide by the medical regulations, and all allaws, rules and regulations, and all allaws, rules and regulations. As explained patients. As explained patients continued to services where radio the hospital to performers.	e of individuals with delineated ithin the Hospital; ew, evaluation and monitoring tices through a systematic quality assessment and of clinical privileges for Medical and assignment of patient care ther health care professionals widual qualification and of competency of care of subject to the Medical Staff process, and reporting to the andings with regard to such of such of the patient care of the medical staff was soard for the patient care of the patient care of patients only to a competency of care of	A 049	care are transferred to emergency rooms at le hospitals with which S a transfer agreement. Variances in practice widentified and analyze the risk management s and reported to the m staff if significant occurrences arise or trare found. 7. Emergency medical ca evaluated by SVH med staff review of perform data provided by local hospitals with which Staff review of perform data provided by local hospitals with which Staff review of Personal Director • Medical Director • President of the Medical • CEO • Regulatory Compliance Complian	ocal VH has will be d via system edical rends re is ical nance VH has Staff Officer nclude lality eliness nd	9/25/08

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I` ′	ULTIPLE C LDI NG	CONSTRUCTION	(X3) DATE	SURVEY LETED
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	PROVIDER OR SUPPLIER	ic		8001 B	ADDRESS, CITY, STATE, ZIP CODE RUCEVILLE ROAD AMENTO, CA 95823		
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	had not resolved the addition, the medic consultants to be consultants (orthop Despite these arrar Board and Medical had not evaluated to these off-campus proposed by the medical states of the medical	is organizational flaw. In al staff had not arranged for redentialed and privileged to or frequently needed medical edics, podiatry, cardiology). Ingements that violated both Staff Bylaws, the medical staff he quality of performance by roviders and reported to the figure and reported to the staff bylaws, approved 2/25/08, al Executive Committee to ction of Infection Control was 1.4.9 described the Infection ies: ance of Facility infection for identifying, reporting, ance and major causes of ections ement a corrective action infection hazards and health; icies;	A	The more as redires 8/1	to the SVH medical staff Board of Trustees. Data be collected monthly a reported quarterly. A contractor evaluation has been adopted for consistent and systema data collection. An oversight committee created by the SVH Med Director to review qual care and performance call patient care contract Members include SVH m staff, the SVH Regulato Compliance Officer, and vendor representatives committee reports to the Medical staff and MEC at through them to the Board of Trustees no less than annually. Oversight will be provided Quality Council, MEC and Board of Trustees through regular agenda items. Sierra Vista medical staff initors infection control active required by the bylaws. Underston of the medical staff, 1/2008 the following action re initiated. An evaluation of the Infection Control Programs completed by an external Best Practices.	form form tic was dical ity of data on ctors. hedical iry d . This he and heard of ed by d the gh now ivities der the on ns	9/30/08

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.			(X3) DATE : COMPL	TE SURVEY MPLETED	
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	responsible for the splans in those affect. When asked on 7/1 aware that there was submitted infection of Pharmacy and Ther Quality Assurance Costaff stated that was some management also confirmed that is showing that after 20 been notified about the infection control. 3) The responsibility according to Section Medical Staff Bylaws for the patient care prendered by all [practinovolvement in the mand improvement of outcomes through a management program. As explained in A 03 1111, the emergency unscheduled walk-in patients did not compolicies and procedu 900.22, 900.23, 900. rules and regulations Emergency services by a qualified member was immediately avaremergency medical compositions.	practitioner (ICP), and were successful corrective action ted areas. 6/08 at 4 p.m. if they were s no evidence that ICP had control reports to the apeutics Committee or to the committee, administrative why the hospital had made changes. Administrative staff there was no documentation 206, the Governing Board had the infection control reports or plan. of the Medical Staff, 2.2.1(e) of the 2/25/08 s, was to account to the Board processes and outcomes titioners] through "active reasurement, assessment, patient care processes and valid and reliable quality	A 049	expert on 9/8/-08 thr 9/12/08. Based on the evaluation, the Medical Staff comprehensive revised the Intervised to Intervised the Intervised to Intervised to Intervised the Intervised to Intervised the	ne rely fection am hese d by taff on were ical th e ection of the ual to the /08.	9/30/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	Continued From pa	ge /2		1. QI monitoring of the qual emergency services care provided both on and off has been initiated through systematic data gathering analysis of quality indicated chart review of care propatients found to have a emergency medical condand review of quality performance data from a campus providers of emergency care. 2. Sierra Vista Hospital now that all emergency care supervised by a qualified member of the medical supervised by a qualified member of the Medical Director • Medical Director • President of the Medical Staff now ensure compliance state and federal laws, inclusivation of the medical staff, in July, 20 following actions were initiated. 1. Training of RNs in accordance with an astandardized procedure. 2. Monitoring of competing procedure of Medical Screening Exams.	f campus gh ng and ators, vided to n dition, off ergency v ensures is I staff. dical with ding ection of 108, the ted. approved ure. etency ualified g in the cal	9/30/08 8/1/08 9/24/08 8/1/08
{				3. Oversight of RN perf	ormance	

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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ĺ	PROVIDER OR SUPPLIER VISTA HOSPITAL, II	NC		STREET ADDRESS, CITY, STATE, ZIP C 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823	ODE		
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	Continued From pa	age 12A		of Medical Screen by SVH designate of the SVH medical. 4. Approval of the standardized procedure and creen Interdisciplinary Recommittee by the Policy Committee medical staff on Standard of on 9/30/08. Individual(s) responsible: • Medical Director • President of the Meterial Don-QMP RN Trainer • Regulatory Complian How Monitored: • Method of monitorial 100% audit of MSE documentation for completeness, accumentation for completeness, accumentation for completeness are addressed and Board Trustees.	d members al staff. tandardized eation of an Practices e Medical of the SVH 0/24/08 and Trustees edical staff er nce Officer mg is via uracy, and dure. essed via n. s / other actices eports to	8/1/08	
				Evidence: Minutes of Quality Council	9/16/08		

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION	(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 049	did not receive emeto patients throughor capability of the host were not identified the assessment and persystem, and were not board. 4) As explained in A the hospital was properties to Assessment and Repractices for evalual patients that include by registered nurses trained and without standardized proced law. Medical screen conducted by social were not approved (per medical staff ruled) a physician in acceptation (California Medical F482.12(e)(1) CONTENTE The governing body services performed in a safe and effective in a safe	ergency services comparable but the hospital and within the spital. These deficiencies by an event-driven quality reformance improvement of reported to the governing a 0347, A 1111 and A 1112, oviding emergency services EMTALA requirements. Efferral staff described ting unscheduled walk-in dimedical screening exams is who were not appropriately the guidance of a dure in accordance with state hing exams were also workers and clinicians who qualified Medical Personnel les and regulations Section rmitted delegation of this task cordance with state law Practice Act). RACTED SERVICES	A 049		ning s re vices. tions n has	10/2/08

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
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	PROVIDER OR SUPPLIER VISTA HOSPITAL, IN	c	}	8001	ADDRESS, CITY, STATE, ZIP CODE BRUCEVILLE ROAD RAMENTO, CA 95823		
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	Based on staff inter document reviews, ensure that services agreements with loc of 2 transfer agreem effective, permitted services, and includ the home hospital. services to be performings: Policy 900.26 Contralisted the services pragreement as Radio Services, MRI service procedure included the process and establismonitoring quality" at through the Performing Section 3.10(b) of the Bylaws obliged the Bindividuals, who provibut who were not sulprivilege delineation provide such service expected to receive information regarding	views, medical record and the governing body failed to a performed under transfer cal acute care hospitals (for 2 ments reviewed) were safe, assessment for quality of the ed specific tasks needed by The hospital also permitted rmed by a suspended vendor. Act Services, revised 10/06, rovided by contract or logy, Laboratory, Emergency res, and others. The o "stipulate the referral to the mechanism for and to monitor for quality cance Improvement Process. Be 11/16/06 Board of Trustees roard to assure that all rided patient care services opect to the Medical Staff process, were competent to so In addition, the Board reports of quality assurance	A 084	3.	systematic data collection. Quality Indicators have beed derived from the form and tracking and trending procestablished. An oversight committee was created by the SVH Medical Director to review quality of and performance data on a patient care contractors. Members include SVH medical staff, the SVH Regulatory Compliance Officer, and verepresentatives. This committees and through them to the Board of Trustees no less thannually. A Transfer Agreement amendment was finalized of 9/25/2008 for both local hospitals contracted with the Hospital. This Amendment has been reviewed by Methodist Hospital and Kaiser Foundation Hospital Society approved.	en a a a a ess s of care ll cal ndor nittee and ne nan	10/2/08 10/2/08 9/25/08
	process. A Transfer Agreemer SVH dated 4/15/08 w The agreement desc Need for Transfer se admitting and readmi	nt Between [Hospital A] and as reviewed on 7/22/08. ribed (in the Determining ction) provisions for tting patients between the he Conditions to Transfer		5.	A new Service Agreement w written for a local outpatien diagnostic clinical radiology service. This new agreement specifies roles and responsibilities of each organization for the care an	nt nt	10/2/08

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I` ´	ULTIPLE CONSTRUCTION LDING	(X3) DATE COMP	SURVEY LETED
	_	054087	B. WIN	NG	08/	01/2008
	PROVIDER OR SUPPLIER	c		STREET ADDRESS, CITY, STATE, ZIP C 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823		
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	"admission criteria in personnel, and equipatient." Certain es exchanged betweer possible." Non-eme arranged in advance Hospital A to make outpatient diagnostic designated by the a federal and state law agreement did not exphysician would be inpatient attending a department practitio delineate the specificabs, x-ray, MRI, CT (cardiology, orthope agreement did not distinguished a formal movement from one outpatient services. On 7/18/08 at 5 p.m. between the hospital care hospitals were The CEO acknowled listed the specific emservices (lab, x-ray, preliminary and final for SVH patients. No established a formal records to be provided service was rendered other hospitals. The establish a means of (staff communication delivery of care and in the stablished a formal records to care and individual to the stablish a means of (staff communication delivery of care and individual to the stablish a means of (staff communication delivery of care and individual to the stablish a means of (staff communication delivery of care and individual to the stablish a means of (staff communication delivery of care and individual to the stablish a means of (staff communication delivery of care and individual to the stablish a means of (staff communication delivery of care and individual to the stablish a means of (staff communication delivery of care and individual to the stablish a means of (staff communication delivery of care and individual to the stablish a means of (staff communication delivery of care and individual to the stablish a means of (staff communication delivery of care and individual to the stablish a means of (staff communication delivery of care and individual to the stablish a means of (staff communication delivery of care and individual to the stablish a means of (staff communication delivery of care and individual to the stablish and the stablish a means of (staff communication delivery of care and individual to the stablish and the stablish a means of (staff communication delivery of care and individual to the st	relating to appropriate bed, ipment necessary to treat the isential information was to be in the facilities "as promptly as ergency care was to be e. The agreement required available to the patient its c and therapeutic services as ttending physician subject to ws and regulations. The explain who the attending (the SVH psychiatrist, the at Hospital A, or an emergency iner at Hospital A); and did not c services such as STAT, specialty consultation dic, neurology). The istinguish a formal transfer ervices (or inpatient to d vice versa), from temporary facility to another for transfer agreements I and two neighboring acute discussed with CEO of SVH. dged that neither agreement in specialty consultation, reports) desired and needed or was there language that expectation for treatment ed to SVH at the time the did (or when available) by the	A 0	the time of the hospit physician order to the the patient. This doct defines the quality over this service. 6. Radiologists will mainst Hospital medical staff as consultant member 7. A second agreement for radiology services is in Individual(s) responsible: • CEO • Medical Director • President of the Medical Director • Regulatory Compliance How Monitored: • Patient Care Contract reviewed for performan by the MEG Board of Tannually. • The Director of PI is responsible collecting, & reporting monitoring • Reports will be made Medical State and througe	al return of ument also ersight of tain privileges s. or on-site process. cal Staff e Officer cts are for ice quality and rustees e for analyzing g evidence e to the aff, MEC th them to of Trustees	10/2/08

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LDING	NG	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 084	B provided access of QAPI data, credenti information for SVH there was no reciproreview the same information for SVH there was no reciproreview the same information agreement had no posservices. The CEO in an interfection of the contracted services a few vendors that pexample, the laborate reports about timeling requests and turnare attended meetings awhere some quality. However, specifically to these hospitals, the data reflecting the number of the period of the services provided to hospitals. The agreed directly audit operation colonials. The agreed directly audit operation colonials and the colonials of the period of the services provided to hospitals. The agreed directly audit operation colonials and the colonials of the greed directly audit operation colonials and the greed directly audit operation colonials. The agreed directly audit operation colonials and the greed directly audit operation colonia	for that hospital to review aling and peer review operations and providers, ocal agreement for SVH to cormation for operations and at B. The Hospital A provision for SVH to access or performance information to oligation of the contracted eview conducted on 7/23/08 at revious statements by the quality assessments for were event driven, except for provided reports. For tory contractor provided ress of responding to labound times. CEO stated she at the neighboring hospitals reports were shared. If the neighboring hospitals reports were shared and the hospitals did not provide and the hospitals did not provide and the state of hospital acquired automes (death or disability), or x-ray overread statistics on diffilms on SVH patients. All did serve as an ongoing and quality assessment for the SVH patients by the other ements did not permit SVH to ons of the other hospitals. The contract with the eye and integrated into the hospital's poite the death of Patient 8 in the was an event opportunity to his contract.		• Copy of ev • N • Copy of ev	and more frequently f indicated. ridence /endor Evaluation Form Quality Indicator Tracking and Trending Plan Amendment to Transfer Agreement	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
i		054087	B WIN	NG		08/0	01/2008
	PROVIDER OR SUPPLIER	c			TREET ADDRESS, CITY, STATE, ZIP CODE 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823		
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A 092	February 2008 found contract who were in contracted mobile in granted privileges to level of care for SVI finding, CEO indicate radiology vendors with decision to suspend not occur until the MExecutive Committer noted in meeting missurvey, Patient 13 with suspended vendors. Hospital staff (PHY Manager, RN 7) were restriction for radiological contracted hospitals rooms. (Refer to A CEO acknowledged have an open MRI of who need an open	d that radiologists under eading films taken by a ray company were not provide this direct medical patients. As a result of the led that the contracts with the led that the contracts with the led that the contracted services did lay 19, 2008 Medical led Ad Hoc meeting (approval nutes). During the present leas sent to one of the for a wrist MRI on 7/15/08. F, PHY I, PHY J, A/B Unit led not familiar with the logic services to just the two through their emergency 0346, A 0546 and A 1103) that the local hospital did not apability and that for patients MRI, the hospital had no leat complied with the leation) to render the service. Autdated amendment (from the agreement with Hospital A les including radiology there of the agreement had several times and the currently valid. CEO planned transfer agreements to the services desired, timeliness and reports, and to seek the services. ENCY SERVICES s are provided at the must comply with the	A 09		482.12(f)(1) EMERGENCY SERVICES Sierra Vista Hospital now ensure	es	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD	LDING (X3) DATE S			
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ł	PROVIDER OR SUPPLIER	c	S	TREET ADDRESS, CITY, STATE, ZIP CODE 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823			
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	This STANDARD is Based on observation record and document to comply with the return the Condition of Emevidenced by: 1. failure to integrate department the servinpatient units such emergency medical stabilizing treatment hospital and equivale inpatients [cross refe? failure to ensure communication betworviders authorized transfer agreement [3. failure to ensure to procedures were foll reference A 1104]; 4. failure to ensure to supervised by a qual staff during all period were offered and availabilizing treatment.	s not met as evidenced by: on, staff interviews, medical int reviews, the hospital failed equirements of CFR 482.55, ergency Services, as e into the emergency ices that were available to the that patients presenting with conditions received within the capability of the ent to treatments offered to erence A 1103]; timely and effective veen off-campus emergency to provide care under a cross reference A 1103]; emergency policies and owed by hospital staff [cross that emergency services were ified member of the medical its that emergency services ailable [cross reference A that personnel (RN's)	A 09:	compliance with the requirem CFR 482.55, the condition of emergency services. 1. The facility now ensures to services available to inpate units are integrated into the Assessment and Referral assuch that patients present with emergency condition receive stabilizing initial treatment with the capability the hospital and equivalent treatments offered to inpate a. All patients presenting an unscheduled assess who are deemed to hemergency medical condition (EMC) will restabilizing treatment the capability of the hospital. b. Clinical Services Polices Polices 900.18 Emergency Screening and Initial Assessment, 900.20 A Screening Exam and 9 Emergency Care were amended to include condition(s) of the physician and RN QMP oversee and provide supervision and stability based on assessed pat needs. c. Sierra Vista Hospital needs.	hat the cient the cient the cient the cient the cient to cient to catients. So for sment cave an ecceive within cies, Medical (00.22) lear e(s) to cization cient	10/2/08	
		tate laws. The hospital ters and clinicians to perform		ensures that it does no			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	c		STREET ADDRESS, CITY, STATE, 2 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823			
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	Continued From pa	ge /8		contracted Transfers a assure doce received. 3. Sierra Vista Hospita that emergency po procedures are foll hospital staff. a. RN's workin Assessment department educated re appropriate of patients	ervices, and initial stabilizing thin the pability and all now ensures we tween the impus ers authorized der a transfer al's transfer has been and now empliance by hospitals. Ire audited to umentation is all now ensures licies and owed by and in the and Referral to (A & R) were egarding the emanagement presenting cas defined 1000.13 cal	10/2/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER SIERRA VISTA HOSPITAL, INC	c		800	EET ADDRESS, CITY, STATE, ZIP CODE 01 BRUCEVILLE ROAD ACRAMENTO, CA 95823		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
Continued From page	ge /8A			and 900.22 the Emergency Care. b. Training included appropriate utilize emergency equipment and calling a Code	ation of ment Blue.	10/2/08
				 Sierra Vista Hospital now of that all emergency care is supervised by a qualified member of the medical st 	5	10/2/08
				5. Sierra Vista Hospital now of that RNs providing medical screening exams (MSE) and stabilizing treatment to pay with emergency medical conditions (EMC) are qualified and functioned in accordation with state laws. a. A new policy was developed (Standation Procedure for Qualified Medical Personnel Registered Nurses #900.40) to define standardized procedure for QMP RNs in accordance with the Title 22, the Nurse Practice Act, and Guidelines for	al did did did did did did did did did di	
				Standardized Proce and was given final approval on 9/30/2 b. Training was provid all RN's who met th	l 2008. ded to	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER VISTA HOSPITAL, IN	3		STREET ADDRESS, CITY, STAT 8001 BRUCEVILLE ROAD SACRAMENTO, CA 950			
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	Continued From pa	ge 18B		Standar c. Competer and professional profession of trained by QMP d. An Interpraction establis 900.41 ensure function Standar in according 22. The reports Board of the professional profes	rdisciplinary es Committee was shed via Policy on 9/24/2008 to the oversight ns related to rdized Procedures rdance with Title IDP Committee to MEC and the if Trustees. sible: etor ursing ssessment and erral Indicator Tool, tes the if the Medical onents, documentation ation for transfer cable) will be a weekly basis or of A & R. nds will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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1	PROVIDER OR SUPPLIER	c		8001 BR	DDRESS, CITY, STATE, ZIP CO NUCEVILLE ROAD NMENTO, CA 95823			
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	Continued From pa	ge 18C			education and staff disciplinary procedures and Referral mainta of all Authorization Transfer forms and 100% of the forms foompleteness to assessment of emecare will be monitored aily review by the Director of the incidence assessments for ade documentation of stand emergency care procedures in accordinate policies and procedures. A sample of medica reflecting initial treepersons who are det to have an emergency condition are now makedly by the Medical Staff, Director, members of Medical Staff, Director Assessment & Referr Deficiencies are immaddressed and result tracked, trended, an and used to improve processes. The Director of Performance	ersment ains a copy of for reviews for sure care and ately ergency red via A&R dent report e to face equate tabilization e rdance with d al records eatment of termined cy nonitored cal of the tor of r of r of ral. nediately ts are nalyzed e clinical		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	c		STREET ADDRESS, CITY, STATE, ZIF 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823	CODE		
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	Continued From pa	ge /8)		Improvement (DF aggregate, analythe data and presented Staff, ME a Quarterly basis. The concurrent trending tool for \$2008 was present September Qualith Meeting on 9/16/ The medical direct the physician onto assure that 24 is provided. Any resupervision issues are reported to the Administrator on the Medical Direct resolution. evidence Policies: 900.18, 900.2, 900.30, 900.40, 900.4, 900.4, 900.4, 1000.13 Memo to A&R RN's QMP Training Module Sample audit tool Tracking and trending Medical Staff schedule Minutes of Quality Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and the Couminutes of MEC 9/17/0 Transfer Agreement Armania Region Staff and Tr	ze and trend sent it to C and BOT on . Tacking and september, sed in the ty Council O8. ctor reviews call schedule /7 coverage medical sthat arise he Call and to tor for 20, 900.22, 1, tool es uncil 9/16/08 08		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER VISTA HOSPITAL, IN	c	{	REET ADDRESS, CITY, STATE, ZIP CODE 3001 BRUCEVILLE ROAD SACRAMENTO, CA 95823		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 092	portions of the med violation of the med regulations. [cross 482.21 QAPI	ical screening exam in ical staff rules and	A 092			
	maintain an effective data-driven quality a improvement progra. The hospital's gover the program reflects hospital's organization hospital departments those services furnis arrangement); and for to improved health or and reduction of med.	e, ongoing, hospital-wide, issessment and performance im. Ining body must ensure that the complexity of the on and services; involves all is and services (including shed under contract or occuses on indicators related outcomes and the prevention		The Sierra Vista Hospital Gover Board now ensures that all beloidentified departments are evaluating 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	ow aluated	
	Based on observation record and document to develop, implement ongoing hospital-wide assessment and perfiprogram. The program	ormance improvement am failed to involve all and services (including ned under contract or		On August 20, 2008, the following actions were initiated. 1. All hospital performance improvement data for a 2008 was aggregated and reported to Medical Standard Executive Committee. 2. All minutes to Medical Standard Executive Committees reflected to aggregate data reporting information. On September 16, 2008 the following series initiated. 1. All hospital performance.	Staff the	9/1/08 9/1/08 9/30/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		054087	B. WING		08/	08/01/2008	
	PROVIDER OR SUPPLIER VISTA HOSPITAL, IN	c		STREET ADDRESS, CITY, STATE, ZIP CODE 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	A. The QAPI progreffectiveness of ser non-privileged radic agreement) and univendor (Refer to A of B. The QAPI prograeffectiveness of ser non-privileged cons. C. The QAPI prograeffectiveness of emnearby hospitals university (Refer to A 0084 and D. The QAPI prograeffectiveness of ser Assessment and Recoger): E. The QAPI prograeffectiveness of the activities (Refer to A of Canadaministrative of an ongoing program effectively implement A 0310); H. The QAPI prograeffectively implement A 0310;	am failed to evaluate the vices provided by ologists (under transfer der contract with a suspended 0267); am failed to evaluate the vices provided by off-campus ultants (Refer to A 0267); am failed to evaluate the ergency services provided by der a transfer agreement d A 0267); am failed to evaluate the vices provided by the eferral Department (Refer to A or failed to ensure that the experformance improvement ehensive (Refer to A 0265); am failed to evaluate the infection control program and 0267); overning body, medical staff, efficials failed to ensure that for quality improvement was ted and maintained (Refer to mailed to identify omission).	A 2	improvement data for August, 2008 was agg and reported to Mediand Medical Executive Committee. 2. All minutes of Medical Committees reflected aggregate data reportinformation. 3. A new format for reposition control, Pholipital departments (i.e., And Infection Control, Pholipital departments on Oct. On September 24, 2008, the following actions were initiated organ procurement. 1. A meeting was held with Director of Golden Stonor Service with the following agenda: a. Policy Review Revision b. Definition of "Imminent Decomposition of "Imminent Decompos	gregated cal Staff e al Staff d the ting ools for & R, armacy, sed and 1, 2008. ed on with the ate se a and seath" w of Staff croval of cry yed and intent	9/30/08 9/30/08 9/24/08	
		al organ donor to the ocurement agency (Refer to		of the contract agree for organ, tissue and			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	() -	IULTIPLE CONSTRUC	TION	(X3) DATE	SURVEY
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j	PROVIDER OR SUPPLIER	c		STREET ADDRESS, 0 8001 BRUCEVILL SACRAMENTO			
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	Continued From pa	ge 20		Visit Seric Eye Seric State including Gold and 3. And sing 200 State report that cours as report from State report from	curement between ta Hospital and DCI vices, Inc., d/b/a se and Tissue Donor vices (SETDS)/Gold te Donor Services alude a definition forminent death." Inature approval by den State Donor Services of the CEO was compannual review of the Geometric of the death occurring 8 was done. The Gold te Donor Services resentative conclust the death of patient of the death of patient did not be declared resuscitation was stagress and the patient did not meet death." In a mining for staff was reduled for 9/30/08 and ducted by the Gold te Donor Services resentative. All furthing on OPO will be diducted by the Direction of the	I Donor Sierra den and to or the ervices pleted. he g in colden ded ent 1 l at SVH till in ent's et the n of sit the colden den den dicture e ector of dictory) chrough	9/24/08

PHINIEU: 09/19/2006 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 054087 08/01/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8001 BRUCEVILLE ROAD SIERRA VISTA HOSPITAL, INC SACRAMENTO, CA 95823 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (QI (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 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 Medical Staff minutes for August 20,2008 and September 16, 2008 and Quality Council, MEC and Board of Trustees minutes of September 30, 2008 July and August Quality Indicator Graphs Quality Indicator tracking sheets for contractor

performance, A&R department, Infection Control, Dietary, and Organ Procurement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IULTI	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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A 265	The cumulative effer problems resulted in that did not involve services in complian mandated Condition Assessment and Peresultanian (1) QAPI In The program must in an ongoing program improvement in indi	ge 20 ects of these systemic in an ineffective QAPI program all hospital departments and ince with the statutorily in of Participation for Quality erformance Improvement. HEALTH OUTCOMES include, but not be limited to, in that shows measurable cators for which there is improve health outcomes.	A 2	65	482.21(a)(1) QAPI HEALTH OUTCOMES Sierra Vista Hospital now ensures implementation of a comprehens dietary department performance improvement program that incluperformance improvement indicarelative to the current scope of service.	s sive e des	
	Based on performar interview and performation of a department performation of a department performation indicators relative to as evidenced by lack identified food service. Findings: Review of the dietary improvement activities 1:30 p.m., with Regis Director of Dietary Seperformance improve	e hospital failed to ensure the comprehensive dietary ance improvement program			On 10/1/ 08 the following action were initiated: ♦ New dietary department Plindicators were approved by Quality Council, including: • Nutrition screen complete with BMI • Diets are provided consist with the approved diemanual • Nutrition care plans are completed for patien receiving dietary modifications or interventions • Dietary consults are completed timely.	the ed tent et	9/30/08

	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER		[4	REET ADDRESS, CITY, STATE, ZIP CODE 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823		
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A 265	continuity sheet. W for these parameter analysis of the data gathered nightly with deficiencies would be 24-hour period. It w 15, 2008 quality coudepartment was sch quarterly report; how documentation of withe data that was proportion of per activities for nutrition the Board of Directo 482.21(a)(2) QAPI C	hile data was being collected s there was no specific rather the data was being the intent that any secorrected by the next was also noted that on the July incil minutes that the dietary seduled to present their vever there was no attended the meeting or esented. Similarly there was formance improvement in care or dietary services at	A 265 A 267	482.(a)(2) QAPI QUALITY INDICATORS		
	quality indicators, indevents, and other as assess processes of operations. This STANDARD is Based on interview a hospital failed to ensmeasured, tracked, a 1. the processes of pinfection control; 2. the performance of and off-campus pracmedical level of care	not met as evidenced by: nd document review, the ure that quality indicators and analyzed: atient care as related to f nonprivileged radiologists titioners who provided a to hospital patients to ess of their services; and f A&R activities in an		Sierra Vista Hospital now meas analyzes and tracks quality indicators, including adverse polyevents, and other aspects of performance that assess process care, hospital services and operations. 1. Infection Control On September 23, 2008, the following actions were initiated a. Identified Infection Con Quality Indicators as fol PPD testing, Flu and Hepatitis B monitoring f staff, and Hand Hygiene Individual(s) responsible: • Infection Preventionist	eses of trol lows:	9/23/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
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	appropriateness of and the completion nutritional consults that all elements for benchmark level de however it was also recommendation for consults was to con of problem identificated also recorded for the continued recommendation for consults was to con of problem identificated also recorded for the continued recommendation and refrige was also noted that the exception of 1 m no documented evid improvement progradietary services was identified problem, recollection on parameters was identified. Review of the dietary improvement activitied 2:30 p.m. in conjunct Management and redietary department of improvement progradepartment specific in 2008, revealed the holeveloped in response 2/08. It was also not parameters that were diet indicated on admits and the developed in response 2/08. It was also not parameters that were diet indicated on admits and the continued of the continued and the continued a	of nutrition assessments, assigned nutrition care levels of physician ordered within 48 hours. It was noted 2007 were above the 90% termined by the hospital; noted that the physician ordered nutrition tinue to monitor despite lack ation. These elements were effirst quarter of 2008 with the indation to continue ervices monitoring activities in related to food, dish rator/freezer temperatures. It the resulting compliance, with ionth, was 100%. There was lence that the performance in for either nutrition care or developed in response to an ather it continued to be data effers for which no problem of department performance es occurred on 7/17/08 at the tion with the Director of Risk vealed that currently the lid not have a performance in. Review of hospital-wide indicators for June and July ospital wide indicators were se to survey deficiencies in	A 265	Individuals responsible: Director of Dietary Department Director of Pl How Monitored: Data will be collected monthly by the Dietary Department Director The Pl director will aggregate, analyze and the data on a monthly lengarterly to the Quality Council. Copy of Evidence Dietary Department tracking and trendi worksheet	trend basis / t PI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
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	Findings: 1. Infection Control On 7/15/08 at 8:30 at to review the hospital performance improving infection control. On 7/15/08 at 10:45 stated that the infection control had the infection control had the infection control programmer. On 7/16/08 at 12:35 interviewed. The ICF hospital's 2006 infection control programmer. The 2006 infection control programmer in the following was not the following was not the following was not the two page plan control plan directed committee was response of infections and analysis of data causes of infections. Under the organization control plan also directed the Hospital Pharmac Committee, quarterly issues shall be preserved.	a.m., a request was made to al's quality assessment vement (QAPI) plan for a.m., administrative staff tion control practitioner (ICP) ntrol QAPI program plan with p.m., the ICP was provided copies of the stion control plan, and the gram yearly report for 2006. ontrol plan was reviewed and ted: onsisted of five sections, organization, surveillance aks. ed organization, the infection that the infection control possible for the surveillance of s, at risk processes, review related to incidence and on section the infection cotted that, "As a member of ceuticals and Therapeutics report and infection control	A 26	How Monitored: All will be monitored and collected monthly by the Infection Preventionist All data will be reported Director of PI for aggregat trending purposes and the results reported to the Quality results reported to the Quality Council. Infection Control Manual revised and presented to Quality Council on Septer 18, 2008. Copy of evidence: Minute Infection Control Comminand Quality Council September, 2008. Mon-privileged radiologists On 9/23/2008 the following act were initiated. a. An application for med staff membership & privileges is in process for radiologist who will ove the quality of care provided the quality of care provided by the medical staff on 9/30/08. C. Member of the medical with privileges in radiologic care provided will oversee the quality radiologic care provided will report evaluation of the medical will report evaluation	to ate and equality mber es of ttee cions lical for a ersee rided. or or oved 9/30/08 staff ogy of 10/03/08 d and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	COMPLETED 08/01/2008	
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A 267	was reviewed. The documented the nu developed infection included one case of cases of Hepatitis (methicillin resistant six cases of Scabies) During the interview evidence that these been analyzed by the practitioner also state measured tracked, a infection control info On 7/16/08 at 4 p.m (CEO), confirmed the that the ICP had me infection control quaprocesses of care rebeen assessed by the medical staff, manage body. 2. Performance of no In an interview with the ICP had me infection control quaprocesses of care rebeen assessed by the medical staff, manage body. 2. Performance of no In an interview with the ICP had me infection control quaprocesses of care rebeen assessed by the medical staff, manage body. 2. Performance of no In an interview with the ICP had me interview with the ICP had me infection control quaprocesses of care rebeen assessed by the medical staff, manage body. 2. Performance of no In an interview with the ICP had me interview with the ICP had me infection control quaprocesses of care rebeen assessed by the medical staff, manage body. 2. Performance of no In an interview with the ICP had me infection control quaprocesses of care rebeen assessed by the medical staff, manage body. 2. Performance of no In an interview with the ICP had me infection control quaprocesses of care rebeen assessed by the medical staff, manage body. 2. Performance of no In an interview with the ICP had me infection control quaprocesses of care rebeen assessed by the medical staff, manage body. 2. Performance of no In an interview with the ICP had me infection control quaprocesses of care rebeen assessed by the infection control quaprocesses of care rebeen assessed by the infection control quaprocesses of care rebeen assessed by the infection control quaprocesses of care rebeen assessed by the infection control quaprocesses of care rebeen assessed by the infection control quaprocesses of care rebeen assessed by the infection control quaprocesses of care rebeen assessed by the infection control quaprocesses of ca	yearly infection control report imber of inpatients who is. The infections listed of positive tuberculosis, ten is four cases of MRSA is staphylococcus aureus), and is. In the ICP could provide no infection control issues had e hospital. The ICP is that she had not analyzed or reported any rmation after 2006. In the Chief executive officer at hospital had no evidence asured, analyzed, or tracked lity indicators or that elated to infection control had be ICP and reported to the gement staff, or the governing conprivileged practitioners The Medical Staff Coordinator is p.m., a copy of the Medical itewed. The Roster did not sts. The Roster listed as amily physicians, one psychologist. The MSC had formance evaluations for k-rays for Patients 1, 13, 20,	A 267	quality of care proviot the medical staff and Board of Trustees quantum d. Mobile radiology serve provided on order. Parequiring emergency care are transferred emergency rooms at hospitals with which a transfer agreement e. Emergency medical devaluated by SVH mestaff review of perfordata provided by locathospitals as specified addendum to the transgreements. Individual(s) responsible: CEO Medical Director Regulatory Compliance How Monitored: Method of monitoring raservices will include moscollection of performanion quality indicators incitimeliness audits, reportaround times, and physisatisfaction with reports received and quarterly to the SVH medical staff Board of Trustees. Data will be collected mand reported quarterly. Oversight will be provided the Quality Council, MEG	d the arterly. rices are atients medical to local SVH has are is dical rmance al in the ensfer adiology onthly ce data cluding t turn ician s reports f and monthly led by	10/06/08

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	NAME OF PROVIDER OR SUPPLIER SIERRA VISTA HOSPITAL, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823		
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	In an interview with at 11:50 a.m., the F Quality Assessment driven. The Risk Mevents related to tracemergency room the when Patient 1 and and consultations with the quality of service practitioners. The Fino other objective reprovided by the nonconsultants. Similarly, the Risk Mobjective evidence from the consultants. Similarly, the Risk Mobjective evidence from the consultants. Similarly, the Risk Mobjective evidence from the hospital B, who the hospital B, who the hospital The Risk Mobjective evidence from the past and the quality services they provide as rates of hospital medication errors, publication errors, p	the Risk Manager on 7/18/08 Risk Manager stated the t program activities were event lanager provided reports for ansfers to an off-campus at included the occasions Patient 13 received x-ray care with nonprivileged practitioners. In measure, analyze or evaluate the provided by those Risk Manager could produce the performance of the services privileged radiologists and Manager could provide no for the performance of the performance of the performance of the performance for the	A 26	In August, 2008 the following were initiated. a. Developed an Assess and Referral (A & R) Indicator Tool for 100 Concurrent reviews to on September 1, 2000 following indicators a being tracked and moweekly: 5150 Comple Accurately and Comp Applicable, Medical Screening Completed Consent for Assessme Cobra Log, Checked following the medical equities and consent for Assessme Cobra Log, Checked following the medical equities and completed, calls entered into HM calls with supplement Documentation. Individual(s) responsible: Director of A & R Director of Performance Improvement How Monitored: The A & R QI Indicator To be monitored and correct through staff education weekly basis by the Direct A & R. The Director of Performance Improvement A & R.	ment QI 0% o begin 8. The are now onitored eted eletely if ent, On for pment, Total S, Total tal e	8/31/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LDING		(X3) DATE SURVEY COMPLETED	
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	in conjunction with a that A&R patients we contrary to A&R pol of the 30 patients (F 43, 44, 45, 46, 47, 456, 57, 58, 59, 60, 60 to provide a qualifie the patients for the periodical condition punscheduled patient conditions (Patients 58, 60, 63), the hospital (Policy 900, unscheduled patient conditions (Patients 54, 58, 60, and 63), emergency medical 47, 52, 53, 57), the hasfe transportation a (Policy 900.22). The an organized and accemergency patients 0023, A 1079, A 110 In an interview with that 12:40 p.m., the Riactivities of the Assed department were evareview). At the last reprovided reports to the showed 100% compindicators. The Risk provide quality assess accuracy and completion of safe transfers, and	staff interviews, determined betaff interviews, determined betaff interviews, determined betaff interviews, determined betaff interviews. For 27 Patients 35, 36, 37, 38, 39, 42, 48, 49, 50, 51, 52, 53, 54, 55, 61, 62, 63), the hospital failed difference of an emergency betaff interview of an emergency betaff interviews of an emergency medical interviews of the interviews of an emergency medical interviews of the interviews of an emergency medical interviews of an emergency medical interviews of the interviews of an emergency medical interviews of the interviews of an emergency of an em	A 2	Improvement (DI aggregate, analy the data or Medicommittee(s) on basis. Frequency of monguarterly Oversight of find compliance data evidence by the and reported to council. The ongoing contool for Septemb presented in the Quality Council Monguality Council	ze and trend cal Staff a Quarterly mitoring: lings / or other Director of Pl Quality current audit er, 2008 was September Meeting. council September, Pl Concurrent		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
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ľ	PROVIDER OR SUPPLIER VISTA HOSPITAL, IN	С		REET ADDRESS, CITY, STATE, ZIP CODE 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823				
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A 267	Personnel Register items were not procon 8/1/08. The QA oversight of emerge from the A&R depanoncompliant practicould not evaluate t department.	ge 27 ed Nurse. These requested duced prior to the survey exit PI activities that addressed ency and outpatient services rtment did not identify ces of A&R, and thereby he effectiveness of this	A 267					
ASIU	The hospital's gover group or individual vauthority and respon- hospital), medical st officials are responsensuring that an one	rning body (or organized who assumes full legal assibility for operations of the saff, and administrative sible and accountable for going program for quality ned, implemented, and	A 310	482.21(e)(1) EXECUTIVE REPONSIBILITIES Sierra Vista Hospital Governing now ensures and radiology and Emergency Services will be performed under revised agreements. On 10/1/2008, the following acwere initiated:	/or			
	Based on staff intervidocument reviews, to staff and administration of the QAPI reviews individuals who provided and the QAPI reviews patients treated in the Department (A&R) a activities performed in the QAPI reviews infection control,	for services provided to e Assessment and Referral ccurately reflected the		 A contractor evaluation for adopted for consistent and systematic data collection. Quality Indicators have bee derived from the form and tracking and trending proceestablished. An oversight committee was created by the SVH Medical Director to review quality of and performance data on all patient care contractors. Members of this committee include SVH medical staff, the SVH Regulatory Compliance 	n a ess s of care il	10/1/08 10/1/08 10/1/08		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	opportunities, were Findings: 1. Provider Compet Stated in the Board on 11/17/06, in Sec responsibilities of th a) to provide Medica care evaluation, and b) to assure that all patient care service the Medical Staff pri are competent to pre receive reports of que regarding competent subject to the privile The Board also dele Section 8.3(c), the re individuals responsite treatment or care of the ability to obtain in information in terms The medical staff in 2/25/08, defined its pensure that all patier patient care. Section of medical staff prac who were to consult of a Member of the A Staff. Consulting Sta (section 6.9.2) were	ency of Trustees Bylaws, approved tion 3.10 were two the Board: al Staff oversight and quality of the individuals who provide to expect the individuals who provides, but who are not subject to expect the information process, and utility assurance information and utility assurance information and expect the information process. In the individuals who provides the information process that all the information process. In the individuals who provides the information and interpret to the patient's needs. It is own bylaws, approved the patient's needs.	AS	5	Officer, and vendor representatives. This comreports to the Medical state MEC and through them to Board of Trustees no less annually. A Transfer Agreement amendment was finalized 9/25/2008 for both local hospitals contracted with Hospital. This Amendment has fine reviewed by Methodi Hospital and Kaiser Foundation Hospital legal departments and been approved. A new Service Agreement written for a local outpati diagnostic clinical radiolog service. This new agreem specifies roles and responsibilities of each organization for the care a supervision of the patient the time of the hospital physician order to the retuthe patient. This document defines the quality oversig this service. Radiologists will maintain Hospital medical staff privas consultant members.	on the been st South d has was ent sy ent arn of nt also ht of	10/3/08
-		processed for appointment linical privileges comparable of the medical staff.		7.	A second agreement for on radiology services is in pro-		10/6/08

PRINTED: 09/19/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING ___ 054087 08/01/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8001 BRUCEVILLE ROAD SIERRA VISTA HOSPITAL, INC SACRAMENTO, CA 95823 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) A 310 Continued From page 29 A 310 Individual(s) responsible: As explained in A 0347, the medical staff failed to **Medical Director** evaluate the qualifications and performance of 2 President of the Medical Staff specialty consultants and 5 radiologists Regulatory Compliance officer performing a medical level of care to SVH patients. **How Monitored:** In an interview with the Medical Staff Coordinator Patient Care Contracts are (MSC) on 7/18/08 at 3 p.m., a copy of the Medical reviewed for performance Staff Roster was reviewed. The Roster did not quality by the MEC and Board contain any radiologists. The Roster contained of Trustees annually. as consultant staff two family physicians, one The Director of PI is neurologist and one psychologist. The MSC had responsible for collecting, not collected any performance evaluations for analyzing & reporting radiologists reading x-rays for Patients 1, 13, 20, monitoring evidence or 21. The MSC had not collected any Data are reported to the performance evaluations for the orthopedist who Medical Staff, MEC and to the treated Patient 13, or for the podiatrist who Board of Trustees no less than treated Patient 1. annually and more frequently if indicated. In an interview with the Risk Manager on 7/18/08 Copy of evidence at 11:50 a.m., the Risk Manager stated the **Vendor Evaluation** Quality Assessment program activities were event Form driven. The Risk Manager provided reports for Quality Indicator events related to transfers to an off-campus Tracking and emergency room that included the occasions Trending Plan when Patient 1 and Patient 13 received x-ray care Amendment to and consultations with nonprivileged practitioners. Transfer Agreement The reports did not measure, analyze or evaluate the quality of service provided by those 2. Assessment & Referral (A&R) practitioners. The Risk Manager could produce no other objective reflection of the services in August, 2008 the following actions

consultants.

provided by the nonprivileged radiologists and

Similarly, the Risk Manager could provide no

contracted partners, specifically for Hospital A

and Hospital B who had transfer agreements with

the hospital. The risk manager had no process to

objective evidence for the performance of

were initiated.

1. Development of an A & R OI

Indicator Tool for 100%

on September 1, 2008.

2. Indicators monitored weekly

Concurrent reviews started

9/1/08

9/1/08

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION DING	COMPLETED	
		054087	B. WING		08/01/	/2008
	PROVIDER OR SUPPLIER	c	s	TREET ADDRESS, CITY, STATE, ZIP CODE 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823		
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	directly access data reflected the quality services they provide as rates of hospital medication errors, purely delays in treatment, and consistency of Although the hospital the past year, they woutcomes for patient care hospital who musubsequently at the relationships between outcome. In an interview with CEO stated she was was sent to the susping MRI on 7/15/08. CE patients might need specialty consultation organized to provide Radiologists still had members of the medical provided patients. Orthopedis consultants had not privileged by the medical patients. 2. A&R Activities Section 3.10(q) of the approved 11/17/06, of that all patients with the services of the medical patients.	a from those hospitals that of performance for the led to hospital patients, such acquired infections, preventable deaths, falls, x-ray overreads, or timeliness providing medical records. All reported only one death in overe not able to track the ts transferred to an acute may die (or become disabled) other hospital to evaluate en care here and an adverse en care here and an other en care en	A 31	include: 5150 Completed Accurately Medical Scree Completed, Consent for Assessment, EMTALA Log completion, Durable med equipment, Total calls er into HMS, Total calls wis supplemental Documentation Implementation of these correactions was completed on Aug 2008. Individual(s) responsible: Director of A & R Director of Performance Improvement How Monitored: The A & R QI Indicator will be monitored and corrected through staff education on a weekly by the Director of A & evidence of staff education on a weekly by the Director of Perform Improvement (DPI) will aggregate, analyze and the data for Medical Sta Committee(s) on a Quar	ening ical ital ith on. ective gust 31, e	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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approved 2/2 monitor paties and assessment the measures of patient care a valid and reserved. Review of 30 records, for some in conjunction that A&R patic contrary to Adof the 30 paties 43, 44, 45, 46, 56, 57, 58, 58 failed to provie evaluate the pemergency modern for 11 unschamedical conditions (Paties 54, 58, 60 and emergency modern for 11 unschamedical conditions (Paties 54, 58, 60 and emergency modern for 11 unschamedical conditions (Paties 54, 58, 60 and emergency modern for 11 unschamedical conditions (Paties 54, 58, 60 and emergency modern for an organized emergency paties 12:40 p.m., an interview at 12:40 p.m.,	d) of the 25/08, o ent care nent. Sometiment, a re proceed a A&R was cheduled a constant of the constant of th	Medical Staff Bylaws, bliged the medical staff to practices, including intake ection 2.2(e) further required ssessment and improvement esses and outcomes through quality management program. alk-in patients' medical ed and unscheduled patients, aff interviews, determined ere evaluated and processed cies and procedures. For 27 atients 35, 36, 37, 38, 39, 42, 3, 49, 50, 51, 52, 53, 54, 55, 1, 62, and 63), the hospital salified medical person to for the presence of an condition per Policy 900.18. Patients with emergency extients 37, 39, 41, 42, 43, 43, 43, 46, 50, and 6 scheduled patients with conditions (Patients 36, 38, pospital failed to arrange for and appropriate transfers hospital failed to maintain curate central log for Policy 900.24). (Refer to A 6, A 1103 and A 1104) The Risk Manager on 7/31/08 k Manager stated the esment and Referral	A 3	basis. Frequency of monito Quarterly Oversight of findings compliance other evide the Directo reported by of A & R to Council. The ongoing concurre tool for Sep 2008 was pr in the Septe Quality Cou Meeting. Copy of evidence Quality Cou Minutes for September, Attached co R PI Concurr Tool QAPI reviews for Other S a. Infection Contro b. Dietary On August 20, 2008, the foll actions were initiated. Hospital QAPI data f 2008 was aggregated reported to Medical Medical Executive Committee. New indicators for to Dietary Department	/ data or nce by r of PI and Director Quality ent audit tember, resented ember ncil 2008 py of A & rent Audit Services ol owing or July, d and Staff and	9/1/08

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED		
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(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETION DATE	
department were e review). The A&R the Quality Commit compliance in the s Manager was asked assessment docum	the A&R Director provided reports to a Committee which showed 100% be in the selected indicators. The Risk was asked to provide quality and documentation for the accuracy and		Infection Control program were approved. 3. Medical Staff Committee minutes reflected the aggregate data and reported information.		10/1/08	
completion of the A transfer forms, ensi medical staff appro- the Qualified Medic Nurse. These requ produced prior to th	&R packet, completion of urance of safe transfers, and val of the training method for al Personnel Registered ested items were not e survey exit on 8/1/08. The		actions were initiated. 1. Hospital QAPI data fo August, 2008 was agg and reported to Medical Executive	r regated cal Staff	9/30/08	
emergency services did not identify none did not identify dispa	from the A&R department compliant practices of A&R, arities in treatment of A&R		Medical Staff Commit minutes reflect the aggregate data and reflect the commitment of the commitm		9/30/08	
could not evaluate to department. 3. Other Services Section 3.10(r) of the approved 11/17/06, designate individuals and monitor quality of services. When the department, the Board appropriate monitorial of the medical staff by deficient in A 0747, in addition, the governice contracted services department practices.	e Board of Trustees Bylaws, obliged the Board to sor departments to evaluate of care in particular patient re was no designated and must establish an ang and evaluation process. Ingresponsibilities outlined in aws were addressed as infection control oversight. In ang body oversight for (refer to A 0084), dietary is (refer to A 265) and organ,		indicators for reporting concurrent PI department clinical indicators was implemented on Oct 1 Departments included a. A & R, b. Infection Contoc. Pharmacy, d. Dietary c. Organ Procure Individual(s) responsible: • Director of A & R, ICP, Pharmacy, Dietary and the DON	ng nental , 2008. : rol, ement	10/1/08	
	Continued From particles of EACH DEFICIENCY REGULATORY OR LEACH DEFICIENCY OR SUMMARY STAR LEACH DEFICIENCY OR SUMMARY OR SUM	DENTIFICATION NUMBER: 054087 PROVIDER OR SUPPLIER VISTA HOSPITAL, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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.	DENTIFICATION NUMBER: 054087 A BUILLE VISTA HOSPITAL, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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,	PROVIDER OR SUPPLIER VISTA HOSPITAL, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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 OAPI activities in treatment of A&R patients compared to inpatients, did not identify disparities in treatment of A&R patients compared to inpatients, did not identify disparities in treatment of A&R patients compared to inpatients, 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 coversight. In addition, the governing body oversight for control coversight for control cycles (refer to A 2084), dietary department practices (refer to A 0084), dietary department practices (refer to A 2085) and organ.	DENTIFICATION NUMBER: 054087 A BUILDING STREET ADDRESS. CITY, STATE, ZIP CODE 8001 BRUCEVILE ROAD SACRAMENTO, CA 95823 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) SUMMARY STATE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 tlems were not produced prior to the survey exit on 81/108. The QAPI activities that addressed oversight of emergency services from the A&R department 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 for contracted services (refer to A 085), and organ, because the province of Performance Improvement On September 16, 2008 the following actions were initiated. 1. Hospital QAPI data for August, 2008 was aggregated and reported to Medical Staff committee minutes reflect the aggregate data and reported information. 3. A new format and updated indicators for reporting concurrent PI department procure to the provin	

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	Continued From pa	ge 33		following actions were in organ procurement.	itiated on		
				b. Establish for "Imm Death" c. Complete Review of d. Establish Training s e. Obtain sig	nor Service Ind revised In Inent Policy. In a Definition Inent In	9/24/08	
				2. The Organ Procur policy was review amended to meet of the contract ag for organ, tissue a procurement betw Vista Hospital and Services, Inc., d/l Eye and Tissue Do Services (SETDS)/State Donor Service include a definitio "imminent death. Signature approva Golden State Dono and the CEO was 63. An annual review single death occur	red and to the intent greement and eye ween Sierra of DCI Donor to/a Sierra onor Golden toes and to on for " all by the or Services completed. of the	9/24/08	
				2008 was done. It		9/24/08	

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	Continued From pa	ge 33A		& reporti monitorir ♦ Data will be report Medical S and to th	not be as s still in e patient's t meet the inition of n". staff was 30/08 e Golden rices All future will be e Director of nee. In ance ment is ole for g, analyzing ng evidence red to the staff, MEC e Board of no less than and more y if	9/30/08	

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ILDING		COMPLETED	
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	Continued From page 1	age 33 分		concluded that patient 1 could declared at SVI-resuscitation was progress and the condition did not agreed upon de "imminent deat" 4. Training of SVI-completed on 9 conducted by the State Donor Serve representative. training on OPO conducted by the Nursing or design Individual(s) responsible DON Director of Perfor Improve How Monitored: The Director of Perfor Improve Evidence: The Director of Perfor Improve The Director of Perfor Improve How Monitored: The Director of Perfor Improve Evidence: The Director of Perfor Improve The Director of Perfor Improve Data will be report Medical Staff, Medi	not be I as as still in e patient's of meet the inition of th". I staff was /30/08 he Golden vices All future will be he Director of gnee. e: rmance ment I is ollecting, rting nce rted to the C and to the in no less than e frequently	9/30/08	

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A 310 A 316	0886) were not effe 482.21(e)(4) EXEC	ctively accomplished either. UTIVE RESPONSIBILITIES	A 310		
	group or individual valuation authority and responsible for the special structure of the special	rning body (or organized who assumes full legal nsibility for operations of the laff, and administrative sible and accountable for late resources are allocated patients.		482.21(e)(4) Executive Responsibilities Sierra Vista Hospital now ensure that the medical staff and administrative officials are responsible for ensuring an activinfection Control surveillance as prevention program.	ve
	Based on interview,	not met as evidenced by: policy and document review,		 On August On 8/18/08, a ful time RN was designated info Preventionist. 	
	and administrative o accountable for ensi- were allocated for re- developing a hospital was no documentation Control Practitioner (hours a week had in infection control surv	ensure that the medical staff fficials were responsible and uring that adequate resources ducing the risk of patients all acquired infection. There on showing that the Infection (ICP) who worked six to eight a plemented an active reillance and prevention		 The Infection Control (IC) program was reviewed and revised on 08/26/08. (attack 1600.1; IC plan update) The Infection Preventionist attended the Fundamentals Infection Surveillance, Prevention and Control given APIC on 08/11-08/14/08. 	9/23/08 of
	program. Findings: On 7/15/08 at 10 a.m	n., a request was made to		4. The Infection Preventionist current member of APIC.(see attached resume, training certificate)	
	review the hospital's During an interview of administrative staff s copy of the hospital's	infection control plan.		On September 23, 2008, the following actions were initiated. 5. Infection Control Quality Indicators identified as follow a. PPD testing,	9/23/08

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	weekends, had a "v hospital did not have patient health record. During an interview Director of Human F 1/01/08 to 7/15/08, 168 hours (an aver. The Director of Hum ICP worked either Son her other work so During an interview administrative staff sthat the ICP kept the manual and reports "virtual office" and the readily available at the staff also stated the and that they were ninfection control hour A review of the ICP in the ICP was a part to individual was respossibiliting a monthly infection control manuecords in her "virtual records were not available at 12:35 interviewed. The ICI infection control manuecords in her "virtual records were not available at 12:35 interviewed. The ICI infection control manuecords in her "virtual records were not available at 12:35 interviewed. The ICI infection control manuecords in her "virtual records were not available at 12:35 interviewed. The ICI infection control manuecords in her "virtual records were not available at 12:35 interviewed. The ICI infection control manuecords in her "virtual records were not available." The ICP stated that she vito submit a monthly in hospital. The ICP states	iritual office," and that the e copies of her policies or ds. on 7/15/08 at 12:10 p.m., the Resources stated that from the ICP had worked a total of tage of 5.85 hours a week). In an Resources stated that the aturday or Sunday depending chedule. on 7/16/08 at 5 p.m., stated that they were aware thospital's infection control of patient infections in her neat those reports were not the hospital. Administrative ICP was a part time position of aware that the allocated rs were insufficient. ob description disclosed that the position and that the ensible for preparing and or report to the hospital about the estimated that she kept the final, the patient health I office," and that those was not aware that she was infection control report to the dated that she had not not evaluation from the	AS		b. Flu c. Hepatitis B monitor for staff, d. Hepatitis C monitor for patients e. Hand Hygiene. Individual(s) responsible: Infection Preventionist Director of Pl Regulatory Compliance How Monitored: All indicators will be monitored and collecte monthly with quarterly reporting Oversight of findings / compliance data or othe evidence by: All data w reported to Director of aggregate and trending purposes and the results reported to the Quality Council. Dates already reported a Infection Control Comm Infection Control Manual revised and presented to Quality Council on September 16, 2008. Copy of evidence Position description ADON/Infection Preventionist P & P 1600.1, Infection Program	oring Officer ed er fill be PI for s and to hittee: hl o ember n:	

FORM CMS-2567(02-99) Previous Versions Obsolete

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RM CMS-2567	7(02-99) Previous Versions O	bsolete Event ID: J66R11	F	acility ID: CA030000320 If conf	inuation sheet Pag	e35Aot 208

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A 338	The hospital could documentation sho medical staff or governing body and documentation sho medical staff or governing body and documentation should be a staff that operates a governing body and	provide no evidence or wing that the hospital's verning body was aware, buntable for allocating s to ensure the hospital had an and infection control program.	A 33		s under or the
	Based on observation record and document to have an organize under its bylaws and quality of care provides evidenced by: A. The Medical Staff and Regulations as to the requirement for Personnel Registere trained and operate procedures in according a medical Staff qualifications and perpoviding a medical patients at off-campula 0355];	dance with State law [cross		were initiated. 1. Development of a standard procedure for the performs of Medical Screening Exams 2. Training of RNs in accorda with the standardized procedure for training conducted by physical and QMP RN Trainer 3. Monitoring of competency physician or a qualified QM via proctoring in the performance of Medical Screening Exams 4. Oversight of RN performance Medical Screening Exams 4. Oversight of RN performance Medical Screening Exams 5. Approval of the standardize procedure and creation of a Interdisciplinary Practices Committee by the Medical FC Committee of the SVH medical SVH medical FC Committee of the SVH medical SVH medical FC Committee	dized 9/30/08 ance s nce edure; icians 9/30/08 P RN 9/30/08 ce of SVH SVH d 9/30/08 an Policy

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	Continued From pa	ge 36		staff on 9/24/08. 6. Approval of the stand procedure and creati Interdisciplinary Prace Committee by the ME of Trustees on 9/30/0 Individual(s) responsible: • Medical Director • President of the Me • DON-QMP RN Traine • Regulatory Compliant How Monitored: • Method of monitoring for completeness, accommended and addressed via reme education. • The QMP RM Traine accountable for own the monitoring profered for own the monitoring profered for evidence by the Interdisciplinary Profered for evidence by the Interdisciplinary Profered for evidence by the Interdisciplinary Profered for evidence fo	edical Staff er ance Officer ing is via uracy, and standardized ces are edial er - DON is ersight of cess coring is t of findings or other factices eports to of	9/30/08	

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NAME OF P	ROVIDER OR SUPPLIER	004007		STREET ADDRESS, CITY, STATE, ZIP		01/2008	
	VISTA HOSPITAL, IN	IC		8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
IAG	Continued From pa	·			thodist iser pital South is and has ment was utpatient diology ent defines ality ice. Intain f privileges rs. For on-site in process.	10/3/08	
				How Monitored: ◆ Patient Care Contrareviewed for perform quality by the MEC of Trustees annual! ◆ The Director of PI is responsible for coll analyzing & reporting monitoring evidence. ◆ Reports will be made Medical Staff, MEC through them to the	rmance and Board ly. s ecting, ng ee le to the and		

AND PLAN OF CORRECTION		ECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING		COMPLETED	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823		/01/2008	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	Continued From p	age 36C		Trustees no less thand more frequentindicated. Copy of evidence Vendor Eform Quality In Tracking Trending Amendme Transfer In July, 2008, the following were initiated. Development of a sterior for the perior of Medical Screening 2. Training of RNs in accordance with standardized procedure for the perior form. Monitoring of contraining conducted physicians and Quality Trainer Monitoring of contraining conducted physicians and Quality Trainer Monitoring of contraining conducted physicians and Quality Trainer Monitoring of contraining to the suppression of RN perior form. Amonitoring to the suppression of the SVH medical Screen by SVH designated of the SVH medical Screen by SVH designated of the SVH medical staff on Suppression of SVH medical staff on SVH medic	tly if Evaluation Indicator and Plan ent to Agreement Ing actions andardized rformance Exams In the cedure; ed by MP RN Impetency a qualified oring in the dedical Derformance ing Exams d members al staff candardized eation of an Practices Medical of the SVH	9/30/08 9/30/08 9/30/08	

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
l _u		0 54087	B. Wi	NG		01/2008	
i	PROVIDER OR SUPPLIER		<u>,</u>	STREET ADDRESS, CITY, STAT 8001 BRUCEVILLE ROAD SACRAMENTO, CA 958	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
	Continued From page	90 36		procedure a Interdisciplic Committee Board of Tru 9/30/08. Individual(s) respons Medical Direct President of t DON-QMP RN How Monitored: Method of mon 100% audit of documentation completeness adherence to procedure. Variable addressed via education. The DON-RN Q accountable for the monitorin. Frequency of maily Oversight of ficompliance day evidence is by Interdisciplinat Committee, we the MEC and Board Trustees. Minutes docum staff approval.	sible: tor he Medical Staff Trainer nitoring is via MSE on for s, accuracy, and the standardized ariances are remedial MP Trainer is or oversight of g process monitoring is andings / ata or other of the ary Practices with reports to Board of menting medical via the Medical stee on 9/24/08,	9/30/08	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		BUILDING		X3) DATE SURVEY COMPLETED		
		054087	B. WIN	3	08/	01/2008
	PROVIDER OR SUPPLIER	c		STREET ADDRESS, CITY, STATE, ZIP CO 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Continued From pa	ge 36E		 Copy of SVH policy 9 900.41 attached. On 9/16/08, the following were initiated. 		
				1. The revised Infection C Plan, policy and proced manual was presented Medical Staff Committe 09/16/08.	dures to the	9/30/08
				2. The revised Infection C plan, policy and procec manual was presented on 9/17/08 and forward Board of Trustees on 9/ (see attached IC Policy Procedure Table of Con	lures to the MEC ded to the /30/08. and	9/30/08
		•		3. Infection Preventionist data in Medical Staff Coresponsible for Infection on August 19, and Septe 2008.	ommittee n Control	9/30/08
				4. The Infection Control reforwarded to the MEC of 09/17/08 and to the Bo Trustees on 9/30/08 (see	n ard of	9/30/08
				attached 1600.8, HAI St Report 2008, Antibiotic 5. Infection Control Progra evaluation has been don IC program was present Medical Staff committed responsible for Infection function on 9/30/08.	urveillance usage) am annual ne on the ed to e	9/30/08
				Medical Director		

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING		COMPLETED			
		05 408 7	B. WI	VG	08/	01/2008
	PROVIDER OR SUPPLIER	C	•	STREET ADDRESS, CITY, STATE, ZIP CO 8001 BRUCEVILLE ROAD SACRAMENTO, CA 95823	·····	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
	Continued From par	90 36 F		 Regulatory Complian Infection Prevention How Monitored: Method of monitoring monitoring indicator washing compliance, compliance, Flu immunizations, and C vaccinations. Reporequired for SB739 or showing employee an inpatient participation vaccination programs compliance report is each MEC and Board Trustees meetings be 9/30/08. Frequency of monitor ongoing monthly and Oversight of findings compliance data or one evidence by the med committee responsible infection Control and Dates already reported the medical staff con responsible for Infect Control 9/16/08 and 9/17/08. Copy of evidence: Min 8/19/08, 9/9/17/08, and 	g: see IC s: hand- PPD Hepatitis orts ompliance nd on in s. A made at of eginning ing: quarterly / other ical staff le for I MEC ed and to nmittee cion to MEC nutes of 16/08,	
				9/30/08. • Annual evaluation of I Control Prog		