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	050739	A. BUILDING: _____ B. WING: _____	02/18/2023

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CENTINELA HOSPITAL MEDICAL CENTER	**555 E Hardy St Inglewood, CA 90301**

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A000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Complaint Validation survey, authorized by the Center for Medicare and Medicaid Services, conducted on 2/13/2023 through 2/18/2023. Complaint Validation intake: CA00825916 Representing the California Department of Public Health: Health Facility Evaluator Nurse # 43419, Health Facility Evaluator Nurse # 36206, Physician Consultant # 31993, Pharmacy Consultant # 28851 Patient Census: 153 Sample size: 37 The following Conditions of Participation (CoPs) were investigated: 482.12 Governing Body, 482.13 Patient Rights, 482.21 Quality Assurance Performance Improvement (QAPI), 482.22 Medical Staff, 482.23 Nursing Services, 482.25 Pharmaceutica Services, and 482.42 Infection Prevention and Control and Antibiotic Stewardship Programs. The inspection was limited to the specific Conditions of Participation investigated and does not represent the findings of a full inspection of the facility. The facility was found not to be in compliance with the following Condition of Participation: 482.23 Nursing Services and 482.25 Pharmaceutical Services. Deficiencies were issued to the facility as a result of the Complaint Validation survey.	A000		

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

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	On 2/14/2023, at 5:55 p.m., the survey team called an Immediate Jeopardy (IJ - a situation in which the facility's noncompliance with one or more requirements has caused, or is likely to cause, serious injury, harm, impairment, or death to a patient) situation in the presence of Regional Chief Nursing Officer (RCNO), Infection Preventionist (DIP), Chief Executive Officer (CEO), Chief Nursing Officer (CNO), and Quality Director (QD). The facility failed to implement interventions to reduce the risk of blood clot formation or DVT (deep vein thrombosis-formation of a blood clot in a deep vein) in four of five sampled patients (Patient 1, 2, 7, and 8) in the Labor and Delivery unit, who were at risk for developing blood clots. This deficient practice had the potential to increase the risk of patients developing a deep vein thrombosis (DVT) which can lead to a pulmonary embolism (PE-blood clot in the lung), leading to serious injury or death. On 2/18/2023, at 10:30 a.m., the IJ was removed in the presence of the facility's CEO, CNO, and QD after the hospital submitted an acceptable IJ Removal Plan (interventions to correct the deficient practices). The elements of the IJ Removal Plan were verified and confirmed through observation, interview, and record review. The acceptable IJ Removal Plan included: re-education of all nursing staff to assess for patients ' VTE (venous thromboembolism , a condition that occurs when a blood clot forms in a vein) risk, implement preventative measures for VTE, and document these preventative measures for patients at risk for VTE; all health care providers were notified of the facility ' s VTE prophylaxis policy; and implementation of an auditing process to ensure completeness and accuracy of the patients ' VTE risk assessment and intervention.			

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A144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, the hospital failed to: 1. Ensure the content of a Hemorrhage cart (is a set of trays/drawers on wheels used inhospitals for transporting and dispensing of emergency medication/equipment during lifesupport protocols to potentially save life), labeled "hemorrhage cart," match the content list. 2. Ensure one of two emergency or crash (is a set of trays/drawers on wheels used in hospitals fortransporting and dispensing of emergency medication/equipment during life support protocolsto potentially save life) carts, were checked to ensure medical equipment was functional, and supplies and medications were available for use in the event of an emergency. These deficient practices had the potential to result in nonfunctioning equipment and absence of emergency supplies and medications could delay the treatment during an emergency situation which may or may not affect patients ' outcome. Findings: 1. During an observation on 2/13/2023, at 11:35 a.m., inside the "equipment storage" room located on the 8th floor in the 8 East nursing station, there was a cart labeled "HemorrhageCart." Inside the cart's drawer	A144		

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	labeled Drawer #3, the drawer (Drawer #3) had seven (7) peelpacks (sterilization pouch that is a disposable package used in a sterilizer to allow penetrationof the sterilant to the items placed inside). Inside these peel packs were various surgical instruments. During a concurrent interview and record review, on 2/14/202, at 3:07 p.m., in the equipment storage room, in 8 East nursing unit, with Staff 1, the Hemorrhage Cart content list located on top of the cart, was reviewed. Staff 1 confirmed all of the instruments found in the Hemorrhage cart drawer (Drawer #3) were not listed in the content list. Staff 1 stated the cart is for emergency hemorrhage (bleeding). Concurrently, RN 3 stated those instruments could be used for emergency baby delivery. A review of the facility's Policy and Procedure (P&P) titled, Emergency Carts, last reviewed on 6/2021, indicated "... The contents and configuration of the Carts shall be uniform throughout the medical center." 2. During a concurrent interview and record review, on 2/15/2023, at 10:45 a.m., with the Director of the Telemetry Unit (DTU), during the initial tour of the Telemetry Unit (a unit designated for patients requiring cardiac [heart] monitoring), the Crash Cart Checklist, dated 2/2023, was reviewed. The Director of the Telemetry Unit (DTU) stated the emergency or crash carts were used in the event of a code blue (cardiac or respiratory arrest) and should be checked by the designated nursing staff everyshift to ensure the equipment was operational and all supplies and medications were available in case of an emergency. A review of a document on the Telemetry unit, titled "Crash Cart Checklist," dated February			

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	2023, indicated the Crash Cart had not been checked by the night shift staff on 2/01/2023 and 2/11/2023, respectively. The Checklist indicated the Crash Cart should be checked for the following: cart locked, defibrillator (a device that sends an electrical shock prevent or correct an uneven heart rate that is too fast or too slow) tested and light on, required forms on clipboard, gloves and sharp container present, ambu bag (Automated Artificial Manual Breathing Units-a bag valve mask [self-inflating mask] which is a hand-held device used to ventilate patients who are not breathing)/oral airway (a device used to maintain or open a person ' s airway) on top of cart, cart expiration date, high suction machine (medical device primarily used for removing obstructions such as saliva, blood, secretions from a patient ' s airway), and oxygen tank to be present. A review of the facility's Policy and Procedure (P&P) titled, "Emergency Carts," dated 7/2021, indicated all contents and configuration of the Carts shall be uniform throughout the Medical Center. All equipment shall be checked to assure proper functioning; all available supplies and medications shall be suitable for use... B. Nursing Staff 1. Checking of the Carts... A. In each area, a designated nurse or other licensed staff shall inspect the Emergency Cart daily, at the beginning of each shift or anytime the cart is replaced."			
A385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by:	A385		

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	Based on observation, interview and record review, the facility failed to ensure that the Condition of Participation for Nursing Services was met as evidenced by: 1. Failure to ensure six (6) of seven (7) sampled patients (Patient 1, 2, 7, 8, 19, 26) were properly assessed for venous thromboembolism (VTE, a condition that occurs when a blood clot forms in a vein) risk and given appropriate interventions to prevent VTE for those at risk. (Refer to A-0392) 2. Failure to ensure adequate staffing by assigning a registered nurse to provide care for four (4) of four (4) sampled patients (Patient 34, 35, 36, and 37) in addition to performing charge nurse duties. (Refer to A-0392) 3. Failure to ensure registered nurses were competent in the hemodialysis (the process of removing excess fluid and waste from the body of a person whose kidneys are not working correctly) emergency termination procedure for one (1) of two (2) sampled patients (Patient 22). (Refer to A-0397) 4. Failure to notify the physician for one (1) of three (3) sampled patients (Patient 1) when the patient's (Patient 1) vital signs (body temperature, pulse or heart rate, respiratory rate, and blood pressure) were out of the desired parameters or when the fetal monitoring strip (a record indicating the heart rate and rhythm of the unborn baby [fetus]) showed late decelerations (visually apparent decrease in fetal heart rate typically following a uterine contraction [tightening and shortening of the uterine muscles], can be a sign of fetal distress). (Refer to A-0398) 5. Failure to assess one (1) of three (3) sampled patients (Patient 1) complaint of leg			

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	heaviness and follow up with appropriate intervention, and notification of the physician (Anesthesiologist [MD 2]-specializes in developing anesthetic plans and the administration of anesthetics [drugs that cause numbing sensation in certain areas of the body). (Refer to A-0398) 6. Failure to assess and categorize one (1) of three (3) sampled patient ' s (Patient 1) FHR (Fetal Heart Rate-heart rate of unborn baby) tracing per policy and notify the physician of a patient's (Patient 1) Change of condition. (Refer to A-0398) 7. Failure to ensure nursing staff administered Oxytocin (also known as Pitocin, a hormone used to induce labor and to control bleeding after delivery) as ordered by the physician for one (1) of three (3) sampled patients (Patient 1) who was in labor (a series of continuous, progressive contractions of the uterus that lets the fetus move through the birth canal). (Refer to A-0405) The cumulative effect of these deficient practices resulted in the facility's inability to provide quality health care in a safe environment.			
A392	STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b) The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for care of any patient.	A392		

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	This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to: 1. Ensure six (6) of seven (7) sampled patients (Patient 1, 2, 7, 8, 19, 26), were properly assessed for venous thromboembolism (VTE, a condition that occurs when a blood clot forms in a vein) risk and given interventions to prevent VTE for those at risk. This deficient practice had the potential to result in serious harm or death to the patients from a deep vein thrombosis (DVT, a blood clot in the leg) or pulmonary embolism (a blood clot in the lung). 2. Ensure adequate staffing by assigning RN 5 to provide care for four of four sampled patients (Patient 34, 35, 36, and 37), in addition to performing charge nurse duties. This deficient practice had the potential to result in patient needs not being met to assure patient safety. On 2/14/2023, at 5:55 p.m., the survey team called an Immediate Jeopardy (IJ - a situation in which the facility's noncompliance with one or more requirements has caused, or is likely to cause, serious injury, harm, impairment, or death to a patient) situation in the presence of Regional Chief Nursing Officer (RCNO), Infection Preventionist (DIP), Chief Executive Officer (CEO), Chief Nursing Officer (CNO), and Quality Director (QD). The facility failed to implement interventions to reduce the risk of blood clot formation or DVT (deep vein thrombosis-formation of a blood clot in a deep vein), in four of five sampled patients (Patient 1, 2, 7, and 8) in the Labor and Delivery unit, who were at risk for developing blood clots. This deficient practice had the potential to increase the risk of patients developing a deep vein thrombosis (DVT) which can lead to a pulmonary embolism (PE-blood clot in the			

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	lung), leading to serious injury or death. On 2/18/2023, at 10:30 a.m., the IJ was removed in the presence of the facility's CEO, CNO, and QD after the hospital submitted an acceptable IJ Removal Plan (interventions to correct the deficient practices). The elements of the IJ Removal Plan were verified and confirmed through observation, interview, and record review. The acceptable IJ Removal Plan included: re-education of all nursing staff to assess for patients ' VTE (venous thromboembolism , a condition that occurs when a blood clot forms in a vein) risk, implement preventative measures for VTE, and document these preventative measures for patients at risk for VTE; all health care providers were notified of the facility ' s VTE prophylaxis policy; and implementation of an auditing process to ensure completeness and accuracy of the patients ' VTE risk assessment and intervention. Findings: 1. a. A review of Patient 1's History and Physical (H&P), dated 1/11/2023, indicated Patient 1 was admitted to the facility for the onset of labor (the process of a baby being born) on 1/9/2023, at 9:44 p.m., with a past medical history of pregnancy (a condition of having a baby) and gastric bypass surgery (a weight-loss procedure). During a concurrent interview and record review on 2/16/2023, at 2 p.m., with Registered Nurse 4 (RN 4), Patient 1's L&D (Labor and Delivery) Flowsheet was reviewed. RN 4 stated Patient 1's VTE (venous thromboembolism- a condition that occurs when a blood clot forms in a vein) risk assessment score was 3 (high risk [Score range: low risk=0-1, moderate risk=2, high risk=3-4, highest risk=5 and greater]) on			

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	1/10/2023, at 7:25 a.m. RN 4 stated Patient 1 was at high risk for blood clots. RN 4 stated SCDs (sequential compression devices - a method of DVT prevention that improves blood flow in the legs) should have been placed, and the physician should have been notified of the risk. RN 4 stated there was no documentation indicating that SCDs were placed, nor that the physician was notified about Patient 1's VTE risk. During a concurrent interview and record review on, 2/17/2023, at 10 a.m., with the Certified Registered Nurse Anesthetist (CRNA), Patient 1's "Consent for Anesthesia / Moderate Sedation Services" record, dated 1/10/2023, at 4:15 a.m., was reviewed. The CRNA stated Patient 1 received an epidural (a medication that creates numbness from the bellybutton to the legs). CRNA verified that risks of an epidural included the formation of blood clots. A review of Patient 1's Nursing Assessment, dated 1/9/2023, at 9:44 p.m., indicated Patient 1's BMI (body mass index, derived from the weight and height to classify overweight and obesity [BMI greater than 30=obesity] in adults) was 38.6. A review of Patient 1 ' s VTE risk assessment during the admission to the facility on 1/9/2023, at 11:58 p.m., and documented by Registered Nurse 2 (RN 2), indicated Patient 1 ' s VTE risk score was 0 (low risk for blood clot formation). A review of Patient 1's VTE risk assessment dated 1/10/2023, at 7:25 a.m., and documented by Registered Nurse 1 (RN 1), indicated Patient 1 was high risk for VTE based on a BMI greater than 30, history of surgery, and pregnancy. The VTE risk assessment record also indicated Patient 1's VTE risk score was 3 (high risk).			

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	A review of Patient 1's Anesthesia (medicine to prevent pain during a procedure) Record, dated 1/10/2023, indicated Patient 1 received an epidural (the administration of anesthesia to create numbness from the belly button to the legs) on 1/10/2023, at 3:50 a.m. A review of Patient 1's Consent for Anesthesia, dated 1/10/2023, indicated unexpected severe complications with anesthesia can occur and include blood clots. A review of Patient 1's medical records from 1/9/2023 to 1/10/2023, did not indicate a VTE prophylaxis (an intervention to diminish the risk of DVT and PE) was implemented for Patient 1. During an interview on 2/14/2023, at 11:00 a.m., with Registered Nurse 3 (RN 3), RN 3 stated the nursing staff should conduct a VTE risk assessment on the patient (Patient 1) on admission and at each shift and implement and document the VTE prophylaxis intervention if needed. b. A review of Patient 2's History and Physical (H&P), dated 2/12/23, indicated Patient 2 was admitted to the facility for the induction of labor (when a physician starts labor instead of letting labor start on its own) on 2/11/2023, at 12:47 p.m. During a concurrent observation and interview, in the Postpartum Unit, on 2/13/2023, at 11:15 a.m., Patient 2 was awake and alert. Patient 2 was wearing SCDs (Sequential Compression Device-a method of blood clot prevention that improves blood flow in the legs) on her (Patient 2) legs. Patient 2 stated the SCDs were placed in the operating room after she (Patient 2) delivered via cesarean section (C-section, a surgical delivery of a baby through a cut made			

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	on the mother ' s abdomen and uterus) and not while she (Patient 2) was in the Labor & Delivery (L&D) Unit. Patient 2 stated that while she (Patient 2) was in the L&D Unit, she (Patient 2) was unable to walk after her (Patient 2) epidural (a medication that numbs the body from the bellybutton to the upper legs) because she (Patient 2) could not feel her (Patient 2) legs. During a concurrent interview and record review on 2/14/2023, at 10:45 a.m., with Registered Nurse 3 (RN 3) and Registered Nurse 11 (RN 11), Patient 2's medical record was reviewed. RN 11 stated Patient 2 was admitted on 2/11/2023 for labor. RN 11 stated Patient 2 scored a 2 on VTE risk upon admission, on 2/11/2023 at 5:30 p.m., indicating Patient 2 was at moderate risk of developing a blood clot. RN 11 stated Patient 2 ' s risk factors included pregnancy, and a BMI (body mass index, measure of fat based on height and weight) over 30 (indicates obesity). In addition, RN 3 stated Patient 2 had a history of a major surgery, however, this was not documented in the VTE assessment. RN 3 stated that when the VTE score is two or higher, the computer prompts the nurse to place SCDs on the patient (Patient 2) and to notify the physician. RN 3 stated that there was no documentation in medical records that SCDs were placed or that the physician was notified. During an interview on 2/13/2023, at 11:15 a.m., with Patient 2, she (Patient 2) stated the nursing staff did not place SCDs (sequential compression devices - a method of DVT prevention that improves blood flow in the legs) on her (Patient 2) legs until 2/13/2023 (after Patient 2 delivered her [Patient 2} baby). A review of Patient 2's VTE (venous			

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	thromboembolism-a condition that occurs when a blood clot forms in a vein) risk assessments record, from 2/11/2023 to 2/14/2023, indicated no documentation of Patient 2's VTE risk assessments and interventions on 2/11/2023 and 2/12/2023. Patient 2's VTE risk assessment record on 2/13/2023 and 2/14/2023 also indicated Patent 2's VTE risk factors were obesity and pregnancy. A review of Patient 2's Labor and Delivery (L&D) flowsheet, dated 2/13/2023, indicated Patient 2 had an epidural on 2/11/2023. c. A review of Patient's History and Physical (H&P), dated 2/12/2023, indicated Patient 7 was admitted to the facility for labor on 2/10/2023, at 9:18 a.m. A review of Patient 7's Delivery Summary, dated 2/13/2023, indicated Patient 7 had an epidural (a medication that creates numbness from the bellybutton to the legs) on 2/10/2023. During an interview on 2/14/2023, at 11:00 a.m., with Registered Nurse 3 (RN 3), RN 3 stated the nurses will put SCDs on their patients when the patients are given epidural because the medicine can immobilize them, causing the patients to be at risk for DVTs. A review of Patient 7's VTE risks assessments from 2/10/2023 to 2/14/2023, did not indicate a VTE prophylaxis (pharmacologic and non-pharmacologic measures to diminish the risk of blood clots and pulmonary emboli [a sudden blockage of a blood vessel in the lung]) was implemented for Patient 7 despite documented VTE risk factors for obesity and pregnancy, and a VTE risk score of 2 (moderate risk for blood clot formation). Likewise, Patient 2 ' s VTE risk assessment form did not indicate a VTE risk assessment was done on 2/11/2023.			

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	During an interview on 2/14/2023, at 11:00 a.m., with Registered Nurse 3 (RN 3), RN 3 stated the nursing staff should conduct a VTE risk assessment on the patient (Patient 7) on admission and at each shift and implement and document the VTE prophylaxis intervention if needed. d. A review of Patient 8's History and Physical (H&P), dated 2/13/2023, indicated Patient 8 was admitted to the facility for labor on 2/13/2023, at 8:46 a.m. A review of Patient 8 ' s Delivery Summary, dated 2/13/2023, indicated Patient 7 had a c-section (caesarian section-the surgical delivery of a baby) on 2/13/2023, at 2:35 p.m. A review of Patient 8's VTE risk assessment record on 2/13/2023, at 10:46 a.m., did not indicate a VTE prophylaxis was implemented for Patient 8, with a VTE risk score of 2 (moderate risk for blood clot formation- [Patient 8 ' s risk factors included obesity and pregnancy]). During an interview on 2/14/2023, at 11:00 a.m., with Registered Nurse 3 (RN 3), RN 3 stated the nursing staff should conduct a VTE risk assessment on the patient (Patient 8) on admission and at each shift and implement and document the VTE prophylaxis intervention if needed. e. A review of Patient 19's "Admission / Registration" form, indicated Patient 19 was admitted to the facility on 2/14/2023, at 6:35 p.m. for hypernatremia (high concentration of sodium [salt] in the blood). During an observation on 2/15/2023, at 10:31 a.m., in the Telemetry Unit (where patients are			

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	under constant electronic monitoring or close observation), Patient 19 was observed awake, alert. Patient 19 was not wearing SCDs (sequential compression devices - a method of DVT prevention that improves blood flow in the legs). A review of Patient 19's VTE Risk Assessment record, dated 2/15/2023, at 10:58 a.m., indicated Patient 19 ' s VTE score was 8 (high risk for blood clot formation). Patient 19 ' s risk factors included age over 75, CHF (congestive heart failure-when the heart muscle does not pump blood as well as it should / AMI (acute myocardial infarction or heart attack) and multi-system disease. No interventions for the prevention of blood clots were documented. f. During an observation on 2/17/2023, at 1:16 p.m., in the medical surgical unit (unit that provides care to patients with a wide variety of conditions), Patient 26 was awake, sitting up on the bed. Patient 26 was wearing the SCD leg sleeves. However, there was no machine pump (SCD-sequential compression devices, a method of DVT prevention that improves blood flow in the legs) at the bedside to inflate and deflate the SCD leg sleeves. During a concurrent interview and record review on 2/17/2023, at 1:30 p.m., with Registered Nurse 8 (RN 8), Patient 2's VTE (venous thromboembolism or blood clot) risk assessment record, dated 2/17/2023, at 1:30 p.m. was reviewed. RN 8 stated Patient 26 was admitted on 2/16/2023 and was on bedrest because he (Patient 26) had surgery. RN 8 stated Patient 26 had a VTE score of 6 and was at high risk for blood clot formation. RN 8 also said Patient 26 ' s SCDs should be connected to a machine (SCD). RN 8 verified there was no SCD machine at the bedside. RN 8 stated a physician ' s order was not required			

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	to order the SCDs or the machine and they (SCDs) should have been ordered upon admission. A review of the facility's VTE risk assessment form, dated July 2013, indicated various factors were risk for VTE, for example: Past Surgery Procedures, Obesity (BMI greater than 30), Pregnancy, and Immobilization (inability to move). It also indicated that a score of 2 or higher needed a VTE prophylaxis intervention. The form also indicated if a patient's total risk score was equal to or greater than 2, call physician. A review of the facility's policy and procedure (P&P) titled, "Assessment and Reassessment of the Patient," dated March 2021, indicated all patients will have ongoing assessments and/or reassessment of their problems/needs/condition performed by a nurse. A review of the facility's policy and procedure (P&P) titled, "Nursing Documentation," dated July 2013, indicated the nurses are to document the patient's VTE risk factor screening on admission and during shift assessment every 12 hours. 2. During a concurrent observation, interview and record review, on 2/15/2023, at 10:10 a.m., in the telemetry Unit (where patients are under constant electronic monitoring or close observation), with the Clinical Supervisor (CS 1), the unit ' s staffing assignment was reviewed. CS 1 stated the charge nurse (RN 5) was assigned to four patients (Patient 34, 35, 36, and 37) of her own (RN 5) while, at the same time, performing charge nurse duties. CS 1 stated the ratio (the number of patients assigned to each registered nurse) for the Telemetry unit was 1:4 (1 nurse to 4 patients).			

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	CS 1 stated she (CS 1) would change the assignment to relieve RN 5 from charge nurse duties. During an interview, on 2/15/2023, at 11:06 a.m., RN 5 stated she (RN 5) should not have been assigned to perform charge nurse duties and assigned to care for four patients at the same time. RN 5 stated she (RN 5) was not able to perform charge nurse duties and be readily available to assist other nurses in case of an emergency. A review of a document titled, "7 West Daily Assignment Sheet," dated 2/15/2023 from 7 a.m. - 7 p.m., indicated RN 5 was assigned to four patients and assigned as the charge nurse. A review of the facility's policy and procedure titled, "Staffing Plan," dated 7/2022, indicated the hospital shall provide staffing by licensed nurses, within the scope of their licensure in accordance with the nurse-to-patient ratios by Title XXII (state law enacted by legislature to establish a licensing and certification standards of health facilities), California Licensing and Certification of Health Facilities in the General Acute Care Hospitals. Telemetry Services: The licensed nurse to patient ratio shall be 1:4 or fewer at all times in the Telemetry Unit. Staffing patterns are upgraded according to patient acuity (a measurement of intensity of nursing care needed by a patient).			
A397	PATIENT CARE ASSIGNMENTS CFR(s): 482.23(b)(5) A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the	A397		

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	specialized qualifications and competence of the nursing staff available. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure Registered Nurse 11, Registered Nurse 12, and Registered Nurse 14 (RN 11, RN 12, RN 14) were competent in the hemodialysis (the process of removing excess fluid and waste from the body of a person whose kidneys are not working correctly) emergency termination procedure (safe process of disconnecting a patient from the dialysis machine in case of an emergency) for one (1) out of nine (9) sampled patients (Patient 22). This deficient practice had the potential to result in inadequate return of blood from the machine to the patient (Patient 22) causing harm or even death during hemodialysis treatment. Findings: A review of Patient 22's, History and Physical (H&P), dated 2/9/2023, indicated Patient 22 was admitted for Anemia (when the body does not have enough healthy red blood cells [carries oxygen to the body ' s tissues]), Gastro-intestinal bleeding (GI Bleeding-disorder in the digestive tract with appearance of blood in the stool), and Hemodialysis (a treatment to filter wastes and water from your blood.) During a concurrent observation and interview on 2/15/2023, at 10:20 a.m., in the 7 West unit, with Registered Nurses 13 and 14 (RN 13, RN 14), Patient 22 who was admitted on 2/9/2023 for anemia, GI bleeding, and Hemodialysis was observed undergoing Hemodialysis (a medical			

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	procedure for cleaning the blood with a special filter). Surveyor asked RN 14 if RN 13 discussed during hand-off (a transfer and acceptance of patient care responsibility achieved through effective communication), prior to starting dialysis for patient 22, the emergency termination of dialysis if the hemodialysis nurse becomes incapacitated. RN 14 stated and was confirmed by RN 13 that there was no instruction provided by RN 13 to RN 14 on how to shut off the dialysis machine in case of an emergency. During a concurrent observation and interview on 2/15/2023, at 10:20 a.m., in the 7 West unit, with RN 13, RN 13 confirmed there was no sign posted in the dialysis machine regarding instructions on how to shut off the Hemodialysis machine safely in case of an emergency. RN 13 stated no training had been provided to non-dialysis nurses on how to shut off the Hemodialysis machine in case of an emergency. During an interview on 2/15/2023, at 10:30 a.m., with RN 11, RN 12 (Nurse Educator) and RN 14, the three Registered Nurses (RN 11, RN 12, RN 14) stated they (RN 11, RN 12, RN 14) had not received Inservice on how to shut off the Hemodialysis machine in case of an emergency such as during a power outage or an incapacitated dialysis nurse during dialysis. The Facility did not have a Policy and Procedure (P&P) regarding emergency termination of dialysis by a non-dialysis staff, and there was no record of non-dialysis Registered Nurses training or in-service for emergencies during hemodialysis including safely shutting shut off dialysis in case of an emergency.			

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A398	SUPERVISION OF CONTRACT STAFF CFR(s): 482.23(b)(6) All licensed nurses who provide services in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of all nursing personnel which occur within the responsibility of the nursing service, regardless of the mechanism through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to: 1. Notify the physician (MD 1) when one (1) of thirty (30) sampled patients' (Patient 1) vital signs (body temperature, pulse or heart rate, respiratory rate, and blood pressure) was out of the desired parameters or when the fetal monitoring strip (a record indicating the heart rate and rhythm of the baby [fetus]) showed late decelerations (visually apparent decrease in fetal heart rate typically following a uterine contraction [tightening and shortening of the uterine muscles], can be a sign of fetal distress). 2. Assess one (1) of thirty (30) sampled patient's (Patient 1) complaint of leg heaviness and follow up with appropriate intervention, and notification of physician (Anesthesiologist [MD 2]-specializes in developing anesthetic plans and the administration of anesthetics [drugs that cause numbing sensation in certain areas of the body]) 3. Assess and categorize one (1) of thirty (30) sampled patient's (Patient 1) FHR (Fetal Heart	A398		

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	Rate-electronic recording and monitoring of the heart rate and rhythm of the unborn baby) tracing per policy and notify MD 1 of Patient 1's Change of condition. These deficient practices resulted in the failure to alert the physician of a potential change of condition for Patient 1 including a potential to result in harm due to delayed treatment. Findings: 1. A review of Patient 1's History & Physical (H&P), dated 1/9/2023, at 9:09 p.m., indicated Patient 1 was admitted from the office (Primary Physician ' s Office) for early labor (a series of continuous, progressive contractions of the uterus that lets the fetus move through the birth canal). Patient 1 ' s prenatal (the time of pregnancy before birth occurs) course was complicated by a history of gastric bypass (a type of weight loss surgery that involves creating a small pouch from the stomach and connecting the newly created pouch directly to the small intestine). A review of Patient 1's medication order, dated 1/9/2023, at 10:30 p.m., indicated Oxytocin (also known as Pitocin-medication administered through the vein to induce labor 30 units/500 milliliters (ml-a unit of measurement) was ordered for Patient 1 and to be used as directed for the induction of labor (prompting the uterus to contract during pregnancy before labor begins on its own). A review of Patient 1's Medication Administration Record (MAR), dated 1/9/2023, at 10:30 p.m., indicated the following: Begin oxytocin infusion at 2 milli-units / minute (mu/min-milliunits [a unit of measurement]). Increase Oxytocin infusion by 2 milli-units every 30 minutes until contractions (pertaining to			

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	uterine contractions) are 2 - 3 minutes or 5 contractions in 10 minutes. May decrease by 2 milli-units/ min if contractions are 1 min and/or increased resting tone (the lowest intra-uterine pressure between contractions). Maximum dose is 20 milli-units/min. and notify Physician. A review of Patient 1's Order Set, dated 1/10/2023, indicated Notify MD for: HR (heart rate) < (less than) 50 or > (more than) 120, SBP (systolic blood pressure-indicates how much pressure the blood is exerting against the artery walls when the heart beats) < (less than) 90 or > (more than) 180, RR (respiratory rate) < (less than) 12 or > (more than) 28, SAO2 (oxygen saturation-balance of oxygen in the blood) < (less than) 90 % A review of Patient 1's L&D (Labor & Delivery) Flowsheet, dated 1/10/2023, and documented by RN 1, indicated the following: At 6 a.m., Patient 1's HR (heart rate) was 125 At 11:15 a.m., Patient 1's HR was 123. At 12:15 p.m., Patient 1's HR was 122. At 1:45 p.m., Patient 1's HR was 131. At 2:15 p.m., Patient 1's HR was 126. At 2:30 p.m., Patient 1's HR was 123. At 3:01 p.m., early and late decelerations (represent the harmful effect of uterine contractions) were noted. Actions included			

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	turning Patient 1 side to side At 3:15 p.m., Patient 1 ' s HR was 122. A review of Patient 1's L&D Flowsheet, dated 1/10/2023, at 5:32 p.m., indicated an oxygen saturation (balance of oxygen in the blood; Normal oxygen saturation is 95% or higher) of 88% (percent-a unit of measurement). There is no documentation that RN 1 further assessed Patient 1's oxygen saturation or communicated with MD 1 that Patient 1 was hypoxic (low oxygen level in blood). A Review of Patient 1's Fetal Monitor Strips, dated 1/10/2023, at 6:32 p.m., and documented by RN 1, indicated uterine contractions (tightening and shortening of the uterine muscles) had a change in shape and duration. The records also indicated that during the same time (1/10/2023 at 6:32 p.m.), Patient 1 vomited. There is no documentation that RN 1 communicated Patient 1 ' s change of condition to MD 1. During a concurrent interview and record review, on 2/16/2023, at 2 p.m., with the Registered Nurse 4 (RN 4), Patient 1 ' s L&D Flowsheet and Fetal Monitoring Strip, dated 1/10/2023, were reviewed. RN 4 stated the physician should have been notified when the heart rate is consistently elevated, and the late decelerations are consistent (happening frequently). RN 4 acknowledged the elevated heart rates and added that the fetal monitoring strip showed that Patient 1 had a HR of 130 that remained elevated for 80 seconds. RN 4 also stated that at 5:50 p.m., Patient 1's HR was 220 for 5 seconds. RN 4 stated Patient 1 ' s fetal monitoring strip also showed some late decelerations (visually apparent decrease in fetal heart rate typically following a uterine			

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	contraction [tightening and shortening of the uterine muscles], can be a sign of fetal distress). RN 4 said she (RN 4) did not see any documentation indicating the physician was notified of the elevated heart rates or of the late deceleration and added that the physician should have been notified. A review of Patient 1's L&D Flowsheet, dated 1/10/2023, at 6:35 p.m., indicated Patient 1 became unresponsive (when someone is not moving and does not respond when you call them or gently shake their shoulders) and a Code Blue (a hospital emergency code to indicate the critical status of a patient) was called by the nursing staff at 6:37 p.m. A review of the facility's Policy and Procedure (P&P) titled, "Fetal Heart Rate Interpretation," dated 1/2023, indicated "At each interval, record a complete assessment of the Fetal Heart Rate (FHR) over time and changes or trends in the FHR pattern over time...If an indeterminate or abnormal FHR pattern is identified, interventions include Reposition the patient, discontinue Oxytocin (a medication that helps start or continue labor), supplemental Oxygen, and notify the patient care provider (physician), and document maternal and fetal response..." A review of the facility's Policy and Procedure (P&P) titled, "Chain of Command," dated 5/13/2020, indicated in situations requiring acute medical care and the presence of a physician, it will be the responsibility of the RN or other associates (including non-nursing disciplines) caring for the patient to contact the treating primary or on-call physician immediately and report the condition of the patient. 2. During a concurrent interview and record			

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	review on 2/15/2023, at 3:02 p.m., with Medical Doctor 1 (MD 1), Patient 1 ' s Medical Record Progress Note, dated 1/10/2023, at 3:30 p.m., was reviewed. Patient 1's Medical Record Progress Note, dated 1/10/2023, at 3:30 p.m., and documented by MD 1 indicated "Patient (Patient 1) denies any pain feels leg heaviness." During an interview with MD 1, on 2/15/2023, at 3:10 p.m., when asked what should be done if an L&D (Labor and Delivery) patient with an epidural (a medication that creates numbness from the bellybutton to the legs) complains of leg heaviness, (MD 1) said that it (pertaining to the leg heaviness) should be evaluated by Anesthesia (Referring to an Anesthesiologist- a doctor who gives a patient medication so they do not feel pain when they are undergoing surgery or procedure). A Review of Patient 1's Labor and Deliver (L&D) Flowsheet Documentation, dated 1/10/2023, documented by RN 1, did not indicate re-evaluating Patient 1 ' s complaint of leg heaviness, which was also noted on MD 1's Medical Record Progress Note. Likewise, there is no documentation Anesthesia was contacted to evaluate Patient 1's complaint of leg heaviness. A review of the Facility's Policy and Procedure (P&P) titled, "Labor Epidural, Administration of continuous Infusion," dated 5/2020, indicated to notify anesthesia if Patient is "Exhibiting or complaining of total paralysis or inability to move her legs..." 3. A review of patient 1 ' s History and Physical (H&P), dated 1/11/2023, indicated Patient 1 was admitted to the facility for the onset of labor (the process of a baby being born) on 1/9/2023, at 9:44 p.m. with a past medical			

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	history of pregnancy (a condition of being pregnant) and gastric bypass surgery (a weight-loss procedure). A review of the Facility's Policy and Procedure (P&P) titled, "Fetal Heart Rate Interpretation," dated 1/2023, included, under Section 1.3 "At each interval, record a complete assessment of the Fetal Heart Rate (FHR-measures the heart rate and rhythm of the unborn baby]) over time including assessing Late Deceleration (gradual Decrease in FHR and return to baseline associated with Uterine contractions [tightening and shortening of the uterine muscles]) or Variable Decelerations (abrupt decrease in FHR below baseline) and Assign a category to describe the tracings to either Category I (Normal), Category II (indeterminate-[require evaluation and continued surveillance and reevaluation], and Category III (Abnormal)." In addition, a review of the Facility's Policy and Procedure (P&P) titled "Fetal Heart Rate Interpretation," dated 1/2023, indicated: a. Category I Does not include any Late or Variable Decelerations (visually apparent, gradual decrease in the fetal heart rate typically following the uterine contraction). b. Category II (Indeterminate) includes Variable Decelerations, and FHR tracings not included in Category I (Normal) or Category III (Abnormal). A review of Patient 1's medical record Labor & Delivery (L&D) Flowsheet, dated 1/10/2023, indicated Patient 1 was assessed and categorized as a Category I Normal (Normal) which was not consistent with the Facility ' s Policy and Procedure for categorizing FHR tracings. Per the Facility Policy, Category 1 did not include Late Deceleration (gradual Decrease in FHR and return to baseline associated with Uterine contractions) or			

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	Variable Decelerations (abrupt decrease in FHR below baseline). A review of patient 1's Medical Record Labor & Delivery (L&D) Flowsheet, dated 1/10/2023, documented by Registered Nurse 1 (RN 1), indicated Patient 1 ' s FHR tracings assessments included Variable decelerations at: 7:30 a.m.; 8:00 a.m.; 8:30 a.m. and 2 p.m. (on 1/10/2023) were all documented as Category I (Normal) which is not consistent with the facility ' s Policy and Procedure which indicated "Category I does not include any Variable Decelerations." (Abrupt decrease in FHR below baseline) A review of Patient 1's Medical Record L&D Flowsheet, dated 1/10/2023, documented by RN 1, indicated Patient 1 ' s FHR tracings assessments included: Late decelerations at 9:30 a.m. and 2 p.m. were all documented as Category I (Normal), which is not consistent with the facility Policy and Procedure which indicated "Category I does not include Late Decelerations." A review of Patient 1's FHR (Fetal Heart Rate) interval assessments, L&D Flowsheets, and OB (Obstetric- specializes in delivering babies and caring for people during pregnancy and after they give birth) Triage documentation (the brief, thorough and systematic maternal and fetal assessment performed when a pregnant woman presents for care, to determine priority for full evaluation) form, dated 1/10/2023, indicated Patient 1 was assessed and categorized as a Category I Normal (Normal) in the FHR interval assessments, L&D flowsheet and OB Triage documentation form from 7:30 a.m. to 6 p.m. During a concurrent interview and record review, on 2/16/2023, at 2:16 p.m., with			

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	Registered Nurse 4 (RN 4), Patient 1's L&D Flowsheet, dated 1/10/2023, was reviewed. Patient 1's L&D Flowsheet indicated Patient 1 ' sFHR had concerning changes including late Deceleration (gradual Decrease in FHR and return to baseline associated with Uterine contractions) or Variable Decelerations (abrupt decrease in FHR below baseline). The Heart rate changes twere not normal, as confirmed by RN 4, but RN 1 documented as normal from 7:30 a.m. to 6 p.m. on the L&D Flowsheet. In addition, RN 1 documented Patient 1's Fetal heart tracing assessments as Normal (category I) despite being abnormal. Likewise, appropriate intervention per policy such as MD notification was not done. RN 4 confirmed that RN 1 did not follow the Facility's Policy and Procedure for Categorizing FHR tracings and implementing interventions required, when Patient 1 had abnormal FHR assessments. Per the Facility Policy, Category 1 did not include Late Deceleration (gradual Decrease in FHR and return to baseline associated with Uterine contractions) or Variable Decelerations (abrupt decrease in FHR below baseline). A review of the Facility's Policy and Procedure (P&P) titled, "Fetal Heart Rate Interpretation," dated 1/2023, included under Section 4. "If an indeterminate or Category II or Abnormal or Category III FHT (Fetal Heart Tone-fetal heart rate) pattern is identified, appropriate interventions included: to reposition patient, discontinue oxytocin (Pitocin) and to notify Patient Provider." A review of Patient 1's Medical Record L&D Flowsheet, dated 1/10/2023, and documented by RN 1, indicated Patient 1's FHR tracings assessments included Variable decelerations at 6 p.m. and 6:30 p.m. documented as Category II (Indeterminate- require evaluation			

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	and continued surveillance and reevaluation]). There was no documentation MD 1 was contacted at 6:00 p.m., on 1/10/2023, when Patient 1 ' s FHR tracing changed to Category II. Likewise, there was no documentation that Oxytocin (also Known as Pitocin) was discontinued per Policy and Procedure when Patient 1's FHR tracing changed to Category II as indicated in the Facility ' s Policy and Procedure. A Review of the facility's Policy and Procedure (P&P) titled, "Oxytocin Administration induction/Augmentation of Labor," dated 5/2020, indicated "The Registered Nurse may discontinue the Oxytocin infusion at any time without a physician order, based on fetal heart tracings or contraction patterns. Then notify physician." During a concurrent interview and record review, on 2/16/2023, at 3:15 p.m., with Registered Nurse 4 (RN 4), Patient 1's medical record was reviewed. Patient 1 ' s Medical Record, dated 1/10/2023, at 2 p.m., indicated RN 1 documented Patient 1 had variable decelerations, the action for Fetal decelerations was moving Patient 1side to side. RN 4 confirmed there was no documentation that RN 1 notified MD 1 of the variable Decelerations. RN 4 stated any changes should be communicated to the MD. RN 4 confirmed Patient 1 was classified as Category II (Indeterminate- require evaluation and continued surveillance and reevaluation]). RN 4 confirmed she (RN 4) would communicate with the MD if a Patient had variable (abrupt decrease in FHR below baseline) and late deceleration (gradual Decrease in FHR [Fetal Heart Rate-heart rate of unborn baby] and return to baseline associated with Uterine contractions).			

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A405	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure nursing staff administered Oxytocin (also known as Pitocin, a hormone used to induce labor and to control bleeding after delivery) as ordered by the physician for one (1) of four (4) sampled patients (Patient 1) who was in labor (a series of continuous, progressive contractions of the uterus that lets the fetus move through the birth canal). This deficient practice had the potential for	A405		

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	unnecessary increase in medication dose and possible increase in the fetal (unborn baby) heart rate resulting to harm or death. Findings: A review of Patient 1's History & Physical (H&P), dated 1/9/2023, at 9:09 p.m., indicated Patient 1 was admitted from the office (primary physician office) for early labor. Patient 1 ' s prenatal (the time a female is pregnant, before birth occurs) course was complicated by a history of gastric bypass (a type of weight loss surgery that involves creating a small pouch from the stomach and connecting the newly created pouch directly to the small intestine). A review of Patient 1's Medication Administration Record (MAR), dated 1/9/2023 at 10:30 p.m., indicated to give Oxytocin (also known as Pitocin) 30 units/500 milliliters (ml-a unit of measurement) as directed for induction of labor. The MAR indicated the following: "Begin oxytocin infusion at 2 milli-units / minute (mu [a unit of measurement]/min). Increase oxytocin infusion by 2 milli-units every 30 minutes until contractions (pertaining to uterine contractions) are 2 - 3 minutes or 5 contractions in 10 minutes. May decrease by 2 milli-units / min if contractions are 1 min and / or increased resting tone (the pressure within the uterus when it is not contracting). Maximum dose is 20 milli-units / min and notify Physician." A review of Patient 1's L&D (Labor & Delivery) Flowsheet, dated 1/10/2023, indicated the following: At 4:00 p.m., Uterine activity was monitored externally, and contractions were 2 - 4 minutes apart.			

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	At 4:15 p.m., Pitocin (or oxytocin, a hormone used to induce labor and to control bleeding after delivery) was initiated at 2 milliunit/min/pump. At 4:31 p.m., uterine contractions were 2 - 4 minutes apart. At 4:45 p.m., Pitocin increased to 4 milliunit/min/pump. At 5:01 p.m., uterine contractions were 2 - 3 minutes apart. At 5:15 p.m., Pitocin increased to 6 milliunit/min/pump. At 5:31 p.m., uterine contractions were 2 - 3 minutes apart. At 5:45 p.m., Pitocin increased to 8 milliunit/min/pump. Contractions were 2 - 3 minutes apart. During a concurrent interview and record review, on 2/16/2023, at 2 p.m., with Registered Nurse 4 (RN 4) Patient 1's L&D (Labor & Delivery) Flowsheet, dated 1/10/2023, was reviewed. RN 4 stated that Patient 1 met the criteria for Oxytocin administration. RN 4 reviewed the documented contractions which were 2 - 3 minutes apart at 5:01 p.m. and 5:31 p.m., as well as the Oxytocin rate increase at 5:15p.m. and 5:45 p.m. RN 4 stated that the increase in Pitocin was appropriate because there was no evidence of tachysystole (more than 5 contractions per 10 minutes in 2 consecutive intervals) and the nurses can use their judgement to increase the dose. During an interview on 2/16/2023, at 2 p.m., with Registered Nurse 4 (RN 4), RN 4 confirmed that the physician's order, and the			

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	facility's policy regarding Oxytocin administration, indicated to "maintain Oxytocin infusion at current rate or decrease rate when labor process is adequate per physician order ... meaning Contractions every 2 - 3 minutes ..." is consistently maintained. RN 4 did not comment as to why Patient 1's Oxytocin rate was increased twice at 5:15 p.m. and 5:31 p.m. despite Patient 1 maintaining contractions every 2-3 minutes between 5:01 p.m. and 5:45 p.m. on 1/10/2023. During an interview on 2/15/2023, at 3:02 p.m., with Physician 1 (MD 1), MD 1 stated that per the facility ' s policy, when a patient is receiving Oxytocin for the induction of labor, the Oxytocin rate should be maintained once the contractions are 2 - 3 minutes apart, and the rate should not be increased. MD 1 said some of the side effects of Oxytocin include tachysystole (more than 5 contractions per 10 minutes in 2 consecutive intervals), late decelerations (visually apparent decrease in fetal heart rate typically following a uterine contraction, can be a sign of fetal distress), and water intoxication (an uncommon and sometimes fatal complication of the infusion of oxytocin for the induction of labor or abortion). A review of the facility's Policy and Procedure (P&P) titled, "Oxytocin Administration Induction / Augmentation of Labor," dated 2/2020, indicated to begin the oxytocin infusion at 2 milli-units / minutes (mu/min), per physician order. Increase oxytocin infusion by 2 mu/min no sooner than every thirty (30) minutes per physician order. Maintain oxytocin infusion at current rate or decrease rate when labor process is adequate per physician order, contractions every 2-3 minutes or Montevideo units (MVU, method of measuring uterine performance during labor) 250 - 300 mmHg (millimeters of mercury-a unit of measurement)			

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	in a 10-minute window (IUPC [intrauterine pressure catheter, a device placed into the amniotic space during labor to measure the strength of uterine contractions]) in place.			
A489	Condition of Participation: Pharmaceutical Se CFR(s): 482.25 §482.25 Condition of Participation: Pharmaceutical Services. The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility did not meet the Condition of Participation for Pharmaceutical Services, as evidenced by: 1. Failure to ensure the air pressure relationships, temperature, and humidity, were compliant at all times, within one (1) of one (1) pharmacy sterile compounding suite (IV room, where pharmacy personnel compounded sterile intravenous (IV, into the vein) for medications. (Refer to A-0501) 2. Failure to ensure one (1) of one (1) sterile compounding suite was free of chipped walls, crevices, debris, indentations, and residues, that could accumulate particles and/or	A489		

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	microorganisms. (Refer to A-0501) 3. Failure to ensure the facility ' s policy and procedures, titled "Oxytocin Administration Induction/ Augmentation of Labor," (last revised in 11/2019), was updated to reflect their current practice as observed during the survey for four (4) of four (4) sampled patients (Patient 1, 2, 7, and 8). (Refer to A-0500) 4. Failure to ensure pharmacists would review the transactions from three (3) of three (3) automated drug dispensing cabinets (ADC, a device that allows nurses in hospitals quick, electronically activated and tracked access to stored medications) located in the Emergency Department (ED) for therapeutic appropriateness, at least retrospectively (Refer to A-0500) 5. Failure to ensure one (1) of 1 pre-filled syringe had proper labeling (Refer to A-0505) 6. Failure to ensure three (3) of 33 sampled patients ' own medications (that were brought to the hospital with them on admission) would be returned to the patients upon discharge, as per policy. As a result, three (3) of 33 sampled patients did not receive their own medications on discharge (Refer to A-0500). The cumulative effect of these systemic deficient practices resulted in the failure of the hospital to deliver pharmaceutical services that safeguard the health of the patients.			
A500	DELIVERY OF DRUGS CFR(s): 482.25(b) §482.25(b) Standard: Delivery of Services In order to provide patient safety, drugs and	A500		

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	biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the hospital failed to: 1. Ensure their policy and procedures, Oxytocin Administration Induction/ Augmentation of Labor (last revised in 11/2019), was updated to reflect their current practice as observed during the survey for four (4) of four sampled patients (Patient 1, 2, 7, and 8). 2. Ensure patients' own medications (that were brought to the hospital with them on admission) would be returned to the patients upon discharge, as per policy. As a result, three (3) of 33 sampled patients did not receive their own medications on discharge. 3. Ensure pharmacists would review the transactions from three (3) of three (3) automated drug dispensing cabinet (ADC, a device that allows nurses in hospitals quick, electronically activated and tracked access to stored medications) located in the Emergency Department (ED) for therapeutic appropriateness, at least retrospectively, prior to medication administration. These failures had a potential for avoidable medication errors and/or misuses of medications that may or may not affect patients' health conditions. Findings: 1. During an observation, on 2/13/2023, at			

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	10:50 a.m., in the medication room located on 8th floor at the Labor & Delivery (L&D) unit, in the presence of Staff 1, director of pharmacy (DOP), pharmacy manager (Pharm 1) and Registered Nurse 3 (RN 3), there were several bags of Oxytocin (a natural hormone that manages key aspects of the reproductive systems, including labor and delivery) intravenous (IV, into the vein) admixtures stored in the automated drug dispensing cabinet. The concentration of the Oxytocin IV admixtures (resulting combination when one or more products are added to an IV [intravenous-administered through the vein]) fluid was 30 units in 500 milliliters (ml- a unit of measurement). A review of the hospital's Policy and Procedures (P&P) titled, Oxytocin Administration Induction / Augmentation of Labor, last revised on 11/2019, indicated " ... set up IV infusion pump with 1000 ml LR (Lactated Ringers Solution-used for replacing fluids and electrolytes in those who have low blood volume or low blood pressure) pre-mixed (ready to use) with Oxytocin 20 units ..." During a concurrent interview and record review, on 2/14/2023, at 10:40 a.m., with the Pharmacy Manager (Pharm 1), the facility ' s P&P titled "Oxytocin Administration Induction/Augmentation of Labor," was reviewed. Pharm 1 stated the standard concentration of Oxytocin IV admixtures was changed to 30 Units/500 ml in 2022. (Pharm 1 presented internal emails that indicated the hospital implemented the new oxytocin concentration on 6/8/2022). Pharm 1 also said the current Oxytocin policy did not reflect the current practice at the hospital, and it had the old concentration. 2. During a concurrent observation and			

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	interview on 2/14/2023, at 11:50 a.m., during a tour of the pharmacy area, with Staff 1, director of pharmacy (DOP), pharmacy manager (Pharm 1), there was an automated drug dispensing cabinet located in a secured storage room. Inside one of the automated drug dispensing cabinets, there were two trays labeled "POM." DOP stated those are Patient's Own Meds (POM). Pharm 1 retrieved the trays and presented four (4) bags of medications that were marked for 3 different patients (Patient 3, 4, and 5). During an interview on 2/14/2023, at 11:53 a.m., with the Director of Pharmacy (DOP), DOP stated those three patients (Patients 3, 4, and 5) had been discharged, and 2 of 3 had been discharged more than 2 months ago (Patient 3 was discharged on 12/21/2022 and Patient 4 was discharged on 11/19/2022). DOP indicated nursing staff did not come to retrieve them (Patient 3 and patient 4 ' s own medications) before the discharge of the patients (Patient 3 and Patient 4). DOP also said when the patient is discharged, nursing staff should come pick up POMs for patients to take home. A review of the hospital ' s Policy and Procedures (P&P) titled, "Use of Patients Personal Medications," last revised in May 2020, indicated "The Department of Pharmaceutical Services shall store all patient ' s owned medications brought to the hospital until the patient is discharged ... If the medication(s) are not claimed upon discharge, they shall be kept in secure storage for 30 days and then destroyed ..." 3. During an interview on 2/13/2023, at 3 p.m., with the pharmacy manager (Pharm 1), Pharm 1 stated the pharmacy department did not retrospectively review medication orders that			

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	were supplied by the automated drug dispensing cabinets in the Emergency Department (ED,). There were three automated drug dispensing cabinets in the ED. During an interview on 2/14/2023, 10:50 a.m., with the Pharmacy Manager (Pharm 1), Pharm 1 stated pharmacy department does not review ED orders except those that are dispensed out of pharmacy or orders entered through the hospital ' s "CPOE" (computerized provider order entry software), or when patient became admitted to the inpatient nursing units and then the pharmacist would perform drug regimen review or medications reconciliation. The ED had 2 systems for medication ordering. A review of the hospital's "Depart Report for ER Patient" with a service date of 2/12/2023, indicated there was a total of 115 patients admitted to the ED; 21 of the 115 were discharged and admitted inpatient to the hospital ' s other patient care units. A review of the inventory lists for the three automated drug dispensing cabinets located in the ED indicated they (pertaining to the automated drug dispensing cabinet) contained a total of 382 types of medications, including a variety of oral medications, injectables, narcotics, and high-risk medications. A review of the facility's Policy and Procedures (P&P) titled, "Medication profile and order review," dated4/2022), indicated "Except in emergent situations, before dispensing the patient ' s medication(s), the pharmacist shall review patient profile information including: potential drug-drug interactions, Therapeutic duplications, drug-disease interactions and incompatibilities, appropriateness of medication, dosage, route of administration ... In emergent situations ... the nurse may			

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	remove the first dose ... providing that the medication is removed ONLY after reviewing the appropriateness including ... Patient ' s allergies, Diagnosis, Height and weight for dose determination, route of administration ... The pharmacist reviews the documentation of all circumstances of when medications are removed from ... automated dispensing cabinet ... The pharmacist shall verify the accuracy of all medications ... " According to a nationally recognized professional association, American Society of Health-System Pharmacists (ASHP, which published numerous authoritative guidelines in pharmacy practice referred by the industry as the standard of practices), the guideline titled "Minimum Standard for Pharmacies in Hospitals," dated 4/13/2012, indicated "All medication orders shall be prospectively reviewed by a pharmacist and assessed in relation to pertinent patient and clinical information before the first dose is administered or made available in an automated dispensing device, except in emergent situations ... There shall be a procedure for retrospective review of these orders." The guideline further suggested "use of [ADC] shall be structured so as to not hinder the pharmacist ' s review of (and opportunity to intervene in) medication orders before the administration of first doses ..."			
A501	PHARMACIST SUPERVISION OF SERVICES CFR(s): 482.25(b)(1) §482.25(b)(1) - All compounding, packaging, and dispensing of drugs and biologicals must be under the supervision of a pharmacist and performed consistent with State and Federal laws. This STANDARD is not met as evidenced by:	A501		

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	Based on observations, interviews and record reviews, the hospital failed to ensure its sterile (germ-free) compounding process (a process of making sterile intravenous medications), was performed in a safe and consistent manner, as evidenced by: 1. Failure to ensure the air pressure relationships, temperature, and humidity, were compliant at all times, within one (1) of one (1) pharmacy sterile compounding suite (IV room, where pharmacy personnel compounded [the process of combining, mixing, or altering ingredients to create a medication tailored to the needs of an individual patient] sterile intravenous [IV, into the vein] medications) 2. Failure to ensure one (1) of one sterile compounding suite was free of chipped walls, crevices, debris, indentations, and residues, that could accumulate particles and/or microorganisms. These failures had a potential for all patients requiring IV medications be exposed to avoidable contamination that may or may not affect patient safety or health. Findings: 1. During a concurrent observation and interview, on 2/15/2023, at 10 a.m., outside the IV (intravenous- administered through the vein) room with the director of pharmacy (DOP) and the pharmacy manager (Pharm 1), the pressure monitor was lit up in red. DOP stated that the red light indicated the pressure of the ante room (a small room between areas of contamination and treatment areas) was below 0.02. A closer look at the monitor indicated the pressure was recorded at +0.0144 inch water column (a measuring unit for air pressure).			

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	During a concurrent interview and record review, on 2/15/2023, at 10:26 a.m., with the Pharmacy Manager (Pharm 1), the IV rooms ' pressure, temperature, and humidity logs for the past 3 months, were reviewed. Pharm 1 stated there were multiple excursions in pressures in the anteroom, and work orders had been sent. There were also multiple temperature excursions in the Clean Room (including every day of January 2023); the temperatures were all above 68 and below 70 degrees Fahrenheit (F-a unit of temperature measurement, Normal temperature is 68 degree F or lower per facility policy). During an interview on 2/15/2023, at 11:10 a.m. with the director of Plant Operations (DPO), DPO stated once the department received work orders, staff (maintenance staff) will come check on the reported issues and leave comment in the computer software. During an interview on 2/15/2023, at 11:45 a.m., with the Director of Pharmacy (DOP), DOP acknowledged each area required proper air pressure differentials to ensure sterile compounding areas could achieve and maintain sterility (the complete elimination or destruction of all forms of microbial life), minimize potential of contamination of the IV medications. During an interview on 2/16/2023, at 2:05 p.m., with the Director of Plant Operations (DPO), DPO stated the facility already had approval to install new HVAC (Heating Ventilation and Air Conditioning system-a type of ventilation system used to provide comfort and acceptable indoor air quality) system to correct the pressure fluctuations and the project is pending to start.			

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	A review of the facility ' s Policy and Procedures (P&P) titled, "Compounded sterile preparations: Quality Assurance Environmental Monitoring, Corrective Action Plan," last revised on3/2022, indicated "the cleanroom must be maintained at a temperature ... 68 [degree F] or lower ... the positive pressure area must be at least ... 0.02 inch water column ..." 2. During a concurrent observation and interview on 2/15/2023, at 10:15 a.m., during an inspection of the IV room with Pharmacy Manager (Pharm 1), the ceiling vent grill in the ante room had multiple discolorations. Pharm 1 was not sure what caused the discolorations. Also, the ceiling light had large hand-sized stain that appeared to be a water mark. During a concurrent observation and interview on 2/15/2023, at 10:20 a.m., in the ante room, with Pharmacy Manager (Pharm 1), there was a bench by the entrance door. Pharm 1 confirmed there were debris under and around the bench. Pharm 1 stated the bench was too heavy to move. Also, there were multiple dents, paint chips, and residues on the walls in the ante room. One of the chipped areas on the wall adjacent to the exhaust vent by the countertop in the ante room was about the size of a fist. In front of the exhaust vent, there was a trash bin blocking the vent. During a concurrent observation inside the clean room to the left of the ante room, there were also multiple crevices and paint chips on the walls, as well as indentations and residues on the floors. During an interview on 2/16/2023, at 2 p.m., with Pharmacy Manager (Pharm 1), Pharm 1 stated she (Pharm 1) measured the chipped wall corner in the ante room, and the measurement was 2.75" in height and 2" in			

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	width (wrapped around). A review of the facility's Policy and Procedures (P&P) titled, "Compounded sterile preparations (CSP)," last revised on 3/2022, indicated "All CSP shall be prepared under conditions and standards as defined by USP 797 ..." A review of the current edition of USP 797 indicated " ... The surfaces of ceilings, walls, floors, fixtures, ... shall be smooth, impervious, free from cracks and crevices, ... thereby promoting cleanability and minimizing spaces in which microorganisms and other contaminants may accumulate ..."			
A505	UNUSABLE DRUGS NOT USED CFR(s): 482.25(b)(3) §482.25(b)(3) - Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use This STANDARD is not met as evidenced by: Based on interviews and record reviews, the hospital failed to ensure one (1) of 1 pre-filled syringe found in the ante room (a small room between areas of contamination and treatment areas) had proper labeling. This deficient practice had a potential for a medication error, and ineffective or outdated medications that may or may not treat patient's condition, and/or lead to patient harm. Findings: During an observation on 2/14/2023, at 10:17 a.m., in the hospital pharmacy IV (intravenous - administered through the vein) room, with the	A505		

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	Pharmacy Manager (Pharm 1), there was one unattended syringe placed in a blue bin on a bench. During a concurrent interview, Pharm 1 confirmed the aforementioned syringe did not have a label and the syringe was filled with 40 milliliters (ml) of unknown/unidentified liquid. Pharm 1 stated a drawn syringe should have a label containing at least the name of the medication, strength, BUD (beyond use date, a date after which the product may not be stored or used), and a lot number (an identifier assigned to a batch of medications). Review of the facility's Policy and Procedures (P&P) titled, "Compounded Sterile Preparations (CSP)," last approved on April 2022, indicated " ... The following must be included on the IV admixture label ... drug and amount of drug ... date and time of expiration ..."			
A749	INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(2) The hospital infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings; This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the hospital failed to: 1. Ensure staff wore appropriate personal protective equipment (PPE-includes use of gloves, gowns, goggles, etc.) and failed to wear an N95 (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) correctly while providing care to one (1) of two	A749		

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	(2) patients (Patient 15) who was diagnosed with Coronavirus (COVID-19, a contagious illness caused by a virus that can spread from person to person) This deficient practice had the potential to place patients at risk of contracting COVID-19. 2. Ensure Four (4) of the 7 peel packs (sterilization pouch that is a disposable package used in a sterilizer to allow penetration of the sterilant to the items placed inside) found in the hemorrhage cart containing sterilized instruments were packaged properly. This deficient practice had the potential to spread infection to the patients. 3. Store three (3) of three (3) corrugated boxes (composed of three different sheets of container board, in which two sheets on the outside are flat liners and the sheet in the middle has rippled shape) away from patient care areas and store patient supplies in a sanitary manner. This deficient practice had the potential to spread infection to the patients. Findings: 1. During an observation, on 2/15/2023, at 10:55 p.m., Patient 15's door was closed. A sign was posted on the door indicating the patient (Patient 15) was under "Enhanced Precautions (involve gown and glove use during high-contact patient care activities for patients with COVID-19)." The Certified Nursing Assistant 1 (CNA 1) opened the door to patient 15 ' s room. CNA 1 was observed wearing a surgical mask underneath a N95 (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) mask, gloves, a gown, and eyeglasses. It was also observed that CNA 1 and the Registered Nurse 6 (RN 6) were both not wearing face shields or eye			

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	protection, while inside Patient 15's room. Concurrently, the Director of Infection Prevention (DIP) stated that patients under "Enhanced Precautions" had COVID-19, and staff should wear an N95 mask, gown, gloves, and a face shield when directly caring for those patients to avoid contaminating themselves, other patients, and other staff. The DIP stated staff should not wear a surgical mask under the N95 mask because it breaks the seal of the N95 mask, and therefore, would not be protected against COVID-19 and has the potential for cross-contamination (the process by which bacteria or other microorganisms are transferred from one substance or object to another, with harmful effect). During an interview, on 2/15/2023, at 11:06 a.m., with Registered Nurse 5 (RN 5), RN 5 stated staff were required to wear an N95 mask, disposable gloves, a gown, shoe covers, a hair cover, and a face shield or eye protection when caring for a patient diagnosed with COVID-19 and under "Enhanced Precautions." RN 5 stated eyeglasses were not considered a form of eye protection. RN 5 also said it was not acceptable to wear a surgical mask under an N95 mask because of the risk of infection to everyone. A review of Patient 15's History & Physical (H&P), dated 2/9/2023, at 11 p.m., indicated Patient 15's diagnoses included COVID-19. A review of the facility's Policy and Procedure (P&P) titled, "COVID-19: Universal PPE for Healthcare Personnel," dated 1/2021, indicated this policy applies to all health care personnel (HCP) whose work necessitates close and prolonged contact (within six feet for at least 15 minutes) with patients, visitors, or other personnel who are in a community with			

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	moderate to substantial COVID-19 Transmission. Options for PPE to protect the eyes include face shield, goggles, and respiratory protection with built in eye protection ...safety glasses with extensions to cover the sides of the eyes may be considered. The policy also indicated to put on N95 mask and ensuring proper seal. 2. During an observation on 2/13/2023, at 11:35 a.m., inside the "equipment storage" room located on the 8th floor in the 8 East nursing station, there was a cart labeled "Hemorrhage Cart." Inside the cart ' s drawer, labeled Drawer #3, there were seven (7) peel packs (sterilization pouch that is a disposable package used in a sterilizer to allow penetration of the sterilant to the items placed inside) containing various surgical instruments. Four (4) of the 7 peel packs were double pouched (a peel pack pouch within another pouch) and the inner pouches had been folded to fit into the outer pouch. During an interview on 2/14/2023, at 3:05 p.m., with the Director of Perioperative Services (DPS), in the equipment storage room in 8 East nursing station, the director of Perioperative Services (DPS) stated the inner pouch should not be folded. He stated those peel packs were not done properly. A Review of the facility's Policy and Procedure (P&P) titled, "Surgical Instrument Sterile Processing," last revised 9/6/2020), indicated "Double packaging in paper-plastic pouches should only be performed if the pouch manufacturer has validated the product for this use. If the item is to be double packaged, two sequentially sized pouches should be used (i.e., the sealed inner pouch should fit inside the other pouch without folding) ..."			

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	3. During an observation on 2/13/2023, at 12:15 p.m., in the Labor & Delivery (L&D) Unit, three corrugated boxes with shipping labels, containing office supplies and patient supplies, were observed on top of a counter in a conference room within the patient care area. During an observation on 2/13/2023, at 3:38 p.m., in the Labor & Delivery (L&D) Unit, four corrugated cardboard boxes with shipping labels, containing patient supplies, were observed in a "Janitor's Room" being utilized as storage room for patient supplies. The "Janitor ' s Room" contained a dirty sink with dark substances on the surface. Patient supplies, including infant socks, beanies, and diapers were also observed in the "Janitor's Room". Concurrently, the Director of Infection Prevention (DIP) stated that corrugated shipping boxes should not be stored in patient care areas due to the potential for cross-contamination. The DIP stated patient supplies should not be stored in the "Janitor's Room" due to possible cross-contaminations. A review of the facility's Policy and Procedure (P&P) titled, "Bloodborne Pathogen Exposure Control Plan," dated 4/2022, indicated in Appendix A "For clean/sterile (free from bacteria or other living microorganisms) supply storage, do not store supplies on window- sills, under sinks, within 3 feet of a sink, or on the floor. Do not allow external cardboard shipping boxes in clean areas (clean supply room, exam rooms etc.). For utility rooms, do not mix storage (clean and dirty items). Do not have eternal shipping boxes in clean supply / utility rooms."			