SVHCD QUALITY COMMITTEE

AGENDA

WEDNESDAY, MAY 24, 2023

5:00 p.m. Regular Session

TO BE HELD VIA ZOOM VIDEOCONFERENCE

To Participate Via Zoom Videoconferencing
use the link below:
https://sonomavalleyhospital-org.zoom.us/j/91601200156?pwd=cXYzdUs2MEZnS2xHVUJyL3phWWdGQT09.

and Enter the **Meeting ID: 916 0120 0156**
Passcode: 891667
To Participate via Telephone only, dial:
1-669-900-9128 or 1-669-219-2599

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a District meeting, please contact the District Clerk, Monique Crayton, at mcrayton@sonomavalleyhospital.org or 707.935.5005 at least 48 hours prior to the meeting.		
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER/ANNOUNCEMENTS	*Kornblatt Idell*	
2. PUBLIC COMMENT SECTION *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.*	*Kornblatt Idell*	
3. CONSENT CALENDAR • Minutes 04.26.23	*Kornblatt Idell*	Action
4. IMAGING QA/PI	*Young*	Inform
5. QUALITY INDICATOR PERFORMANCE AND PLAN	*Cooper*	Inform
6. CENTER FOR IMPROVEMENT IN HEALTHCARE QUALITY CORRECTIVE ACTION PLAN	*Cooper*	Inform
7. POLICIES AND PROCEDURES	*Cooper*	Inform
8. CLOSED SESSION: a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	*Kornblatt Idell*	Action
9. ADJOURN	*Kornblatt Idell*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
April 26, 2023, 5:00 PM
MINUTES
Via Zoom Teleconference

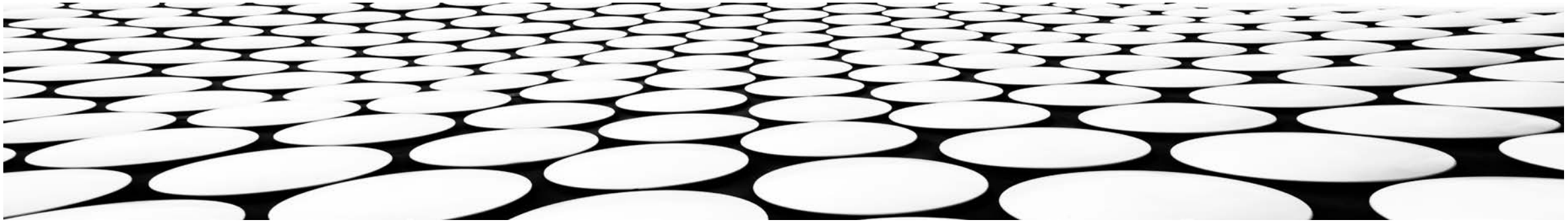
Members Present – Via Zoom	Members Present cont.	Excused	Public/Staff – Via Zoom
Susan Kornblatt Idell Carol Snyder Kathy Beebe, RN PhD Michael Mainardi, MD Howard Eisenstark, MD Ingrid Sheets, EdD, MS, RN Carl Speizer, MD Judith Bjorndal, MD			Jessica Winkler, DNP, RN, NEA-BC, CCRN-K, CNO Kylie Cooper, RN, BSN, CPHQ, MBA, Quality and Risk Mgmt. John Hennelly, CEO Sujatha Sankaran, MD, CMO Stephanie Montecino, Infection Preventionist, Employee Health Nurse

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Kornblatt Idell*	
	Meeting called to order at 5:00 p.m.	
2. PUBLIC COMMENT	*Kornblatt Idell*	
	None	
3. CONSENT CALENDAR	*Kornblatt Idell*	Action
• QC Minutes 03.22.23		**MOTION:** by Bjorndal to approve, 2nd by Eisenstark. All in favor.
4. INFECTION PREVENTION ANNUAL RISK ASSESSMENT PLAN	*Montecino*	Inform
	Stephanie Montecino, Infection Preventionist/Employee Health Nurse, gave an overview of the Infection Prevention Annual Risk Assessment Plan. The risk assessment plan covers inpatient acute medical/surgical, emergency, intensive care, ancillary services, as well as outpatient care settings within the hospital.	

5. QUALITY INDICATOR PERFORMANCE PLAN	*Cooper*	Inform
	Ms. Cooper shared the quality indicator performance for the month of March 2023. She reported that there were no substantial changes to the current performance targets.	
6. PATIENT CARE SERVICES DASHBOARD 1ST QUARTER	*Winkler*	Inform
	Ms. Winkler presented the Patient Care Services Dashboard for the first quarter. No comments were noted.	
7. POLICIES AND PROCEDURES	*Cooper*	Inform
	Summaries of changes were reviewed for the following policies: • Nuclear Medicine Emergency Procedures 7630-179	
8. CLOSED SESSION/REPORT ON CLOSED SESSION	*Kornblatt Idell*	Action
a. Calif. Health & Safety Code §32155: Medical Staff Credentialing & Peer Review Report	Medical Staff Credentialing was reviewed and approved.	**MOTION:** by Mainardi to approve, 2nd by Eisenstark. All in favor.
9. ADJOURN	*Kornblatt Idell*	
	Meeting adjourned at 5:47 p.m.	

DIAGNOSTIC SERVICES – QUALITY ASSURANCE

MAY 2023



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2023 QUALITY MEASURES

CT Tube Quality Control

J	F	M	A	M	J	J	A	S	O	N	D

Contrast Extravasations

J	F	M	A	M	J	J	A	S	O	N	D
1	0	0	0								

Wrong Site/Side

J	F	M	A	M	J	J	A	S	O	N	D
0	0	0	0								

Repeat Analysis

J	F	M	A	M	J	J	A	S	O	N	D

MRI Near Misses

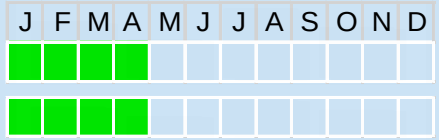
J	F	M	A	M	J	J	A	S	O	N	D
0	0	0	0								

CT Dose Tracking

J	F	M	A	M	J	J	A	S	O	N	D
0	0	0	0								

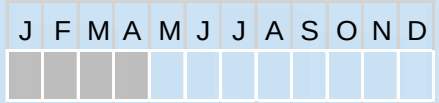
2023 PERFORMANCE IMPROVEMENT

Stroke- Door to CT (< 25 min)
Stroke- Door to Radiologist Report (< 45 min)

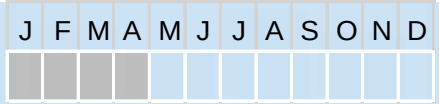


CIHQ QUALITY MEASURES

Contrast Protocols



Albuterol Orders



Quality Indicator Performance & Plan

May Board Quality

Data for April 2023

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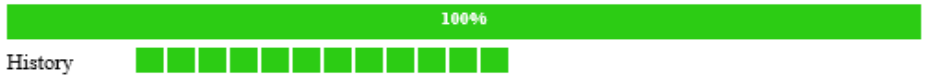
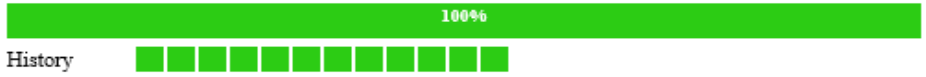
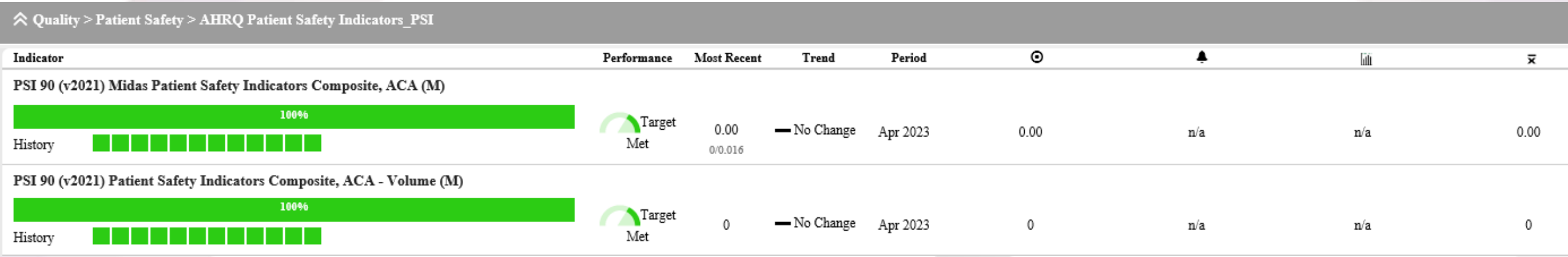
Mortality

Mortality

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Acute Care Mortality Rate (M)								
	Target Met	4.9% 3/61	Improved	Apr 2023	15.3%	n/a	n/a	2.8%
COPD Mortality Rate |M|								
	Target Met	0.0% 0/3	No Change	Apr 2023	8.5%	n/a	n/a	0.0%
Congestive Heart Failure Mortality Rate |M|								
	Target Met	0.0% 0/3	No Change	Apr 2023	11.5%	n/a	n/a	2.0%
Pneumonia Mortality Rate |M|								
	Breaches Alarm	25.0% 1/4	Deteriorated	Apr 2023	15.6%	n/a	n/a	4.5%
Ischemic Stroke Mortality Rate |M|								
	Target Met	0.0% 0/2	No Change	Apr 2023	13.8%	n/a	n/a	0.0%
Hemorrhagic Stroke - Mortality Rate (M)								
	Target Met	0.0% 0/1	No Change	Apr 2023	0.0%	1.0%	n/a	18.2%

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Sepsis, Severe - Mortality Rate (M)								
	Breaches Alarm	50.0% 1/2	Deteriorated	Mar 2023	25.0%	n/a	n/a	4.7%
Septic Shock - Mortality Rate (M)								
	Target Met	0.0% 0/1	Improved	Apr 2023	25.0%	n/a	n/a	11.1%

AHRQ Patient Safety Indicators



The Patient Safety Indicators 90 (PSIs)

- PSI 03 Pressure Ulcer
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 08 In Hospital Fall with Hip Fracture
- PSI 09 Perioperative Hemorrhage or Hematoma
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis
- PSI 11 Postoperative Respiratory Failure
- PSI 12 Perioperative Pulmonary Embolism or DVT
- PSI 13 Postoperative Sepsis
- PSI 14a Postoperative Wound Dehiscence, Open
- PSI 14b Postoperative Wound Dehiscence, Non-Open
- PSI 15 Accidental Puncture or Laceration

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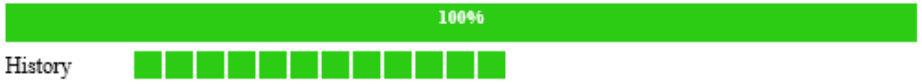
Patient Falls

Preventable Harm

Quality > Patient Safety > Falls

Indicator	Performance	Most Recent	Trend	Period				
RM ACUTE FALL- All (M) per 1000 patient days								
	Target Met	3.31 1/302	Deteriorated	Apr 2023	3.75	4.00	n/a	2.13
RM ACUTE FALL- WITH INJURY (M) per 1000 patient days								
	Target Met	0.00 0/302	No Change	Apr 2023	3.75	4.00	n/a	0.00

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Readmissions

30-DV Inpatients - % Readmit to Acute Care within 30 Days (M)								
	Target Met	13.56% 8/59	Deteriorated	Apr 2023	15.30%	15.50%	n/a	5.96%
COPD, CMS Readm - % Readmit within 30 Days, ACA (M)								
	Breaches Alarm	100.0% 1/1	Deteriorated	Apr 2023	19.5%	20.0%	n/a	10.7%
HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
	Target Met	0.0% 0/3	No Change	Apr 2023	21.6%	22.0%	n/a	2.6%
Hip/Knee, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
	Breaches Alarm	100.0% 1/1		Apr 2023	4.0%	5.0%	n/a	5.9%
PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)								
	Target Met	0.0% 0/3	No Change	Apr 2023	16.6%	17.0%	n/a	5.0%
Sepsis, Severe - % Readmit within 30 Days (M)								
	Target Met	0.0% 0/1	No Change	Mar 2023	12.0%	13.0%	n/a	0.0%
Septic Shock - % Readmit within 30 Days (M)								
	Target Met	1.0% 1/1	Deteriorated	Mar 2023	13.3%	14.0%	n/a	0.3%

Blood Culture Contamination

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔
Blood Cultures -Contamination Rate |RN| (M)						
41% / 59%	Breaches Alarm	6.7% 7/104	Deteriorated	Apr 2023	3.0%	3.1%
History						
Blood Cultures -Contamination Rate |LAB| (M)						
100%	Target Met	0.0% 0/87	Improved	Apr 2023	3.0%	4.0%
History						
Blood Cultures -Total Contamination Rate (M)						
75% / 16% / 9%	Bet. Target & Alarm	3.6% 7/192	Improved	Apr 2023	3.0%	4.0%
History						

Month	RN-Contaminated Culture Reports (num)	Blood Cultures Drawn by RN (den)	Percent
Apr 2023	7	104	6.7%
Mar 2023	6	103	5.8%
Feb 2023	2	95	2.1%
Jan 2023	4	88	4.5%
Dec 2022	4	109	3.7%
Nov 2022	3	124	2.4%
Oct 2022	2	74	2.7%
Sep 2022	0	78	0.0%
Aug 2022	2	88	2.3%
Jul 2022	4	89	4.5%
Jun 2022	3	82	3.7%
May 2022	5	107	4.7%

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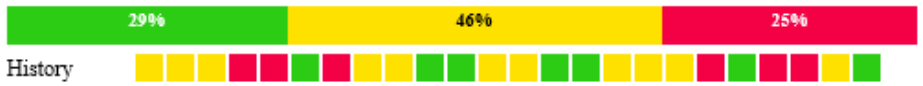
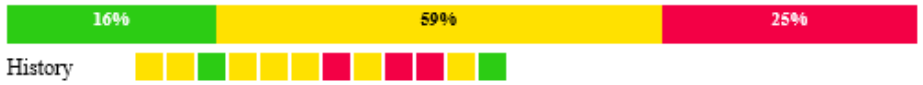
CIHQ Stroke Certification Measures

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
CDSTK-03|Median- Code Stroke Called |M| elapsed time (mins)	Target Met	2	Deteriorated	Apr 2023	10	11	n/a	3
CDSTK-04|Median- Door to Phys Eval |M| minutes	Target Met	0.00	Improved	Apr 2023	10.00	11.00	n/a	0.75
CDSTK-05|Median- Door to CT Scanner |M|elapsed time (minutes)	Target Met	3.50	Deteriorated	Apr 2023	25.00	26.00	n/a	6.00
CDSTK-06|Median- Neuro Consult Contacted |M| minutes	Target Met	13.50	Deteriorated	Apr 2023	30.00	31.00	n/a	15.75
CDSTK-07|Median- CT Read by Radiology |M| minutes	Target Met	30.50	Deteriorated	Apr 2023	45.00	46.00	n/a	29.00
CDSTK-08|Median- Lab Results Posted |M| minutes	Target Met	22.00	Deteriorated	Apr 2023	45.00	46.00	n/a	28.50
CDSTK-10|Median- Door to EKG Complete |M| minutes	Target Met	40.00	Deteriorated	Apr 2023	60.00	61.00	n/a	37.50
CDSTK-11|Median-Door to tPA Decision |M| minutes	Target Met	55.00	Deteriorated	Apr 2023	60.00	61.00	n/a	41.50
CDSTK-12|Median-Door to tPA |M| minutes	Breaches Alarm	76.00		Mar 2023	60.00	61.00	n/a	74.00

Utilization Management

Utilization Management

Indicator	Performance	Most Recent	Trend	Period				
1 Day Stay Rate Medi-Cal [M]								
	Target Met	0.00% 0/18	No Change	Apr 2023	2.61%	5.00%	n/a	3.90%
1 Day Stay Rate-Medicare [M]								
	Target Met	0.00% 0/40	No Change	Apr 2023	8.10%	10.00%	n/a	4.81%
Acute Care - Geometric Mean Length of Stay [M]								
	Breaches Alarm	3.52 45.7459/13	Improved	Apr 2023	2.75	3.23	n/a	3.26
Acute Care Age over 64 - MS-DRG Case Mix Index [M]								
	Target Met	1.64 73.5998/45	Improved	Apr 2023	1.56	1.40	n/a	1.47
Acute Care- MS-DRG Case Mix Index [M]								
	Target Met	1.56 85.6367/55	Improved	Apr 2023	1.55	1.40	n/a	1.48

Geometric mean is a statistical/mathematical term that is applied in many other areas outside of health care. This is calculated by multiplying all of the lengths of stay and then taking the nth root of that number (where n=number of patients). (Minimizes the impact of outliers)

The Case Mix Index (CMI) is the average relative DRG weight of a hospital's inpatient discharges, calculated by summing the Medicare Severity-Diagnosis Related Group (MS-DRG) weight for each discharge and dividing the total by the number of discharges.

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Core Measures

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M)								
	Target Met	100.0% 4/4	— No Change	Apr 2023	88.0%	50.0%	n/a	100.0%
Core OP 18b Median Time ED Arrival to ED Departure - Reporting Measure (M)								
	Breaches Alarm	142.00	Deteriorated	Apr 2023	132.00	140.00	n/a	157.00
Core OP 22 ED LWBS Emergency Dept Left Without Being Seen (M)								
	Target Met	0.3% 2/751	Improved	Apr 2023	2.0%	2.5%	n/a	1.9%
Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)								
	Breaches Alarm	0.0% 0/1	— No Change	Apr 2023	72.0%	70.0%	n/a	63.6%

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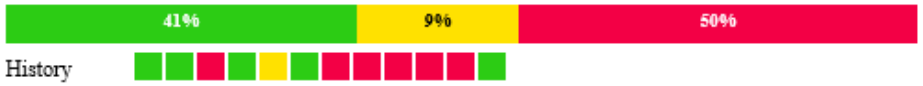
Core Measures Sepsis

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock (M)								
	Target Met	100.0% 2/2	Improved	Apr 2023	81.0%	80.0%	n/a	64.7%
SEPa - Severe Sepsis 3 Hour Bundle (M)								
	Target Met	100.0% 2/2	Improved	Apr 2023	94.0%	90.0%	n/a	86.0%
SEPb - Severe Sepsis 6 Hour Bundle (M)								
	Target Met	100.0% 2/2	No Change	Apr 2023	100.0%	90.0%	n/a	90.7%

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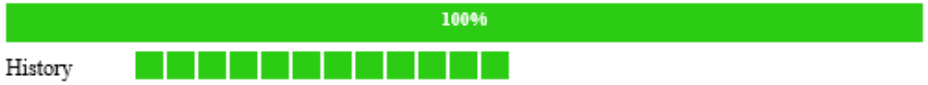
Infection Prevention

Indicator	Performance	Most Recent	Trend	Period	⊙	🔔		✕
IC-Surveillance| HAI-C.DIFF Inpatient infections per 10k pt days |M|								
	Target Met	0	— No Change	Apr 2023	1	1	n/a	0
IC-Surveillance| HAI-CAUTI Inpatient infections per 10k patient days |M|								
	Target Met	0	— No Change	Apr 2023	1	1	n/a	0
IC-Surveillance| HAI-CLABSI Inpatient infections per 10k patient days |M|								
	Target Met	0	— No Change	Apr 2023	1	1	n/a	0
IC-Surveillance| HAI-MRSA Inpatient infections per 10k patient days |M|								
	Target Met	0	— No Change	Apr 2023	1	1	n/a	0
IC-Surveillance| HAI-SSI infections per 10k pt days |M|								
	Target Met	0	— No Change	Apr 2023	1	1	n/a	0

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Patient Satisfaction

Inpatient

Questions	Top Box	n	STATE CA Rank	All PG Database Rank
*Rate hospital 0-10	81.82	55	88	90
*Recommend the hospital	88.46	52	95	96
***Comm w/ Nurses Domain Performance**	86.76	56	96	93
*Nurses treat with courtesy/respect	92.73	55	94	92
*Nurses listen carefully to you	83.93	56	91	90
*Nurses expl in way you understand	83.64	55	95	93
***Response of Hosp Staff Domain Performance**	82.78	50	99	97
*Call button help soon as wanted it	78.72	47	96	94
*Help toileting soon as you wanted	86.84	38	99	98
***Comm w/ Doctors Domain Performance**	80.84	55	67	64
*Doctors treat with courtesy/respect	87.27	55	77	67
*Doctors listen carefully to you	83.02	53	84	82
*Doctors expl in way you understand	72.22	54	38	41
***Hospital Environment Domain Performance**	70.92	53	89	77
*Cleanliness of hospital environment	83.02	53	95	92
*Quietness of hospital environment	58.82	51	78	52
***Comm About Medicines Domain Performance**	67.24	30	86	88
*Tell you what new medicine was for	72.41	29	39	45
*Staff describe medicine side effect	62.07	29	97	97
***Discharge Information Domain Performance**	88.18	49	64	68
*Staff talk about help when you left	87.23	47	73	70
*Info re symptoms/prob to look for	89.13	46	56	57
***Care Transitions Domain Performance**	58.35	51	79	82
*Hosp staff took pref into account	52.00	50	77	79
*Good understanding managing health	52.00	50	53	60
*Understood purpose of taking meds	71.05	38	93	94

*CAHPS

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Ambulatory Surgery

Questions	Top Box	n	All PG Database Rank	State of California Rank
*Facility rating 0-10	76.39	72	4	9
*Recommend the facility	72.60	73	5	9
***Communication Domain Performance**	82.61	74	1	3
*Provided needed info re procedure	83.78	74	2	7
*Instructions good re preparation	83.56	73	1	3
*Procedure info easy to understand	80.82	73	1	1
*Anesthesia info easy to understand	86.96	69	2	6
*Anes side effect easy to understand	77.94	68	8	19
***Facility/Personal Trtment Domain Performance**	94.13	74	8	18
*Check-in run smoothly	93.24	74	23	35
*Facility clean	98.65	74	64	77
*Clerks and receptionists helpful	87.84	74	2	4
*Clerks and reception courteous	93.24	74	6	9
*Staff treat w/ courtesy, respect	97.30	74	28	46
*Staff ensure you were comfortable	94.52	73	13	22
***Discharge Domain Performance**	95.44	74	14	32
*Written discharge instructions	97.18	71	30	40
*Instructions regarding recovery	77.03	74	3	5
*Information re subsequent pain	98.41	63	44	58
*Information re subsequent nausea	100.00	47	99	99
*Information re subsequent bleeding	100.00	54	99	99
*Info on response to infection	100.00	52	99	99
Nurses Overall	80.29	71	5	13
Nurses concern for comfort	82.61	69	8	21
Info nurses gave to prep for proc	83.10	71	13	24
Nurses response concerns/questions	75.00	68	1	3
Care Provider Overall	68.66	70	1	5
CP explanation about proc	72.46	69	2	8
Info CP shared re how proc went	65.22	69	1	3
CP response to concerns/questions	73.13	67	1	7
CP expln why proc important	63.49	63	1	4
Staff worked together care for you	80.00	70	3	6

*CAHPS

Rate My Hospital
Scale 1-5
April Data

Sonoma Valley Hospital / Emergency Department	0	92	4.585 95% CI: 4.523—4.647	
Sonoma Valley Hospital / Inpatient Care	0	3	4.095 95% CI: Not enough samples	

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Rate My Hospital
Scale 1-5

Sonoma Valley Hospital / Medical Imaging	0	192	4.840 95% CI: 4.809—4.871	
Sonoma Valley Hospital / Hand and Physical Therapy	0	98	4.889 95% CI: 4.852—4.926	

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Rate My Hospital
Scale 1-5

Sonoma Valley Hospital / Outpatient Surgery	0	47	4.807 95% CI: 4.748—4.866	

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

CIHQ-AH Corrective Action Plan

» **PRINT** the Corrective Action Plan

Facility Information

Sonoma Valley Hospital Healthcare District
DBA: Sonoma Valley Hospital
347 Andrieux Street
Sonoma, CA 95476-6811
Phone: 707-935-5000
CIHQ ID#: 1004
CCN: 050090

Survey Information

Survey Type: Re-Survey Full Accreditation Survey
Survey Date: 04/18/2023 - 04/21/2023
Corrective Action Plan Due: 05/07/2023

Deficiency #01

Level: Standard–Level
GL-04: Leadership Responsibilities
Requirement: B

The standard was not met as evidenced by the following

REQUIREMENT B

Observed during Document Review (Location #1) – 4/20/23 @ approximately 0900 by A. Martin

Finding: Based on information available at the time of survey, the organization was unable to substantiate that policies are reviewed every three years. The following policies were noted to be past their triennial review date: • Responsibilities of the Dietician (8340-171) last reviewed September 2019.
• Dietician Availability (8340-152) last reviewed May 2015.
• Recording Nutritional Information in the Medical Record (8340-170) last reviewed May 2015.
• Nutritional Products (8340-167) last reviewed May 2015. • Pulmonary Function Testing (7721-62) last reviewed October 2014.
Actual / Potential Outcome: Failure to review policies in a timely manner could result in outdated or no longer applicable practices.
Individual(s) Involved: Leadership
Information Source: Review of above noted policies.
Finding Confirmed by: Staff #1

Action Plan

Action #1

The findings were reviewed with---- Chief Executive Officer on 4/27/23 who directed the action plan be developed.
Failure to review policies in a timely manner could result in outdated or no longer applicable practices which have the potential for harm of patients/staff

Corrective Action 1

Title: Director of Quality (DOQ)
Date: 4/28/2023
Description: The finding was reviewed by DOQ and Quality Systems & Data Analyst (QSDA)

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 4/28/2023
Is a Monitoring Plan Required?: No

Action #2

Corrective Action 2

Title: QSDA
Date: 5/4/2023
Description: QSDA added policies to P&P System with Policies cited to be added to expedited P&P approval workflow for approval by Med Executive committee and the Board of Directors

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 5/9/2023
Is a Monitoring Plan Required?: No

Action #3

Corrective Action 3

Title: QSDA
Date: 5/2/2023
Description: alert to approvers to fast track these approvals to meet up with normal monthly P&P approval flow in order to reach the Board for approval on June 1, 2023

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 5/2/2023
Is a Monitoring Plan Required?: No

Action #4

Corrective Action 4

Title: QSDA
Date: 5/3/2023
Description: Gap Analysis-compile system reports to discern which other policies remain out of compliance for review per policy.

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 5/3/2023
Is a Monitoring Plan Required?: No

Action #5

Corrective Action 5

Title: DOQ
Date: 5/8/2023
Description: Review of Gap Analysis-send to Leadership requiring all outlier policies must be in the P&P Approval workflow no later than June 1, 2023

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 5/8/2023
Is a Monitoring Plan Required?: No

Action #6

Corrective Action 6

Title: QSDA
Date: 5/12/2023
Description: Re compile system reports Review of Gap Analysis-send to DOQ for review

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 5/12/2023
Is a Monitoring Plan Required?: No

Action #7

Corrective Action 7

Title: QSDA
Date: 6/1/2023
Description: report of outstanding policies for review to Quality Committee

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Policies out compliance for required review
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: ongoing
Who will oversee the monitoring: Quality Systems & Data Analyst
What committee in the QAPI program will receive reports on the results: Board Quality

Deficiency #02

Level: Condition–Level
GL-04: Leadership Responsibilities
Requirement: C

The standard was not met as evidenced by the following

REQUIREMENT C
Observed as a Result of Survey Activities – Central Office Determination
Based on the collective result of survey activities, the governing body could not substantiate that it consistently assures compliance to the CMS Conditions of Participation and standards, and accreditation policies of the Center for Improvement in Healthcare Quality as evidenced by the following condition level deficiencies:
• IC-4
• MM-24
• QS-10
Please refer to the specific finding under the above standard for a description of non-compliance. The governing body must establish and implement processes to assure that it provides active oversight and resources to support quality and patient safety. Note that a condition-level deficiency is assigned to the governing body whenever such deficiencies are noted in other standards.
THIS IS A CONDITION LEVEL DEFICIENCY

Action Plan

Action #1
The findings were reviewed with the Chief Executive Officer on 4/27/23 who directed the action plan be developed.
Governing body could not substantiate that it consistently assures compliance with COP and standards and accreditation policies for CIHQ
Action Plan:
Chief Executive officer
5.24.23
See corrective action plans for IC-3, MM-24 and QS-10.
The board quality committee will be informed of this condition level finding at the next Board Quality meeting on 5.24.23. Board Quality members will be provided with reports on progress and status of the corrective actions plans for each deficiency. This will be added to the monthly agenda until all items have been resolved.

Title of Person Responsible for Implementing the Action: Chief Executive Officer
Date Action Plan was or will be Implemented: 5/24/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Corrective Action Plans
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: Until Resolution of CAPs
Who will oversee the monitoring: Director of Quality
What committee in the QAPI program will receive reports on the results: Board Quality Committee

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Deficiency #03

Level: Standard–Level
QA-01: Quality Assessment / Performance Improvement (QA/PI) Program
Requirement: B

The standard was not met as evidenced by the following

REQUIRMENT B
Observed during Document Review (Location #1) – 04/18/23 @ approximately 1210 by A. Martin
Finding: Based on information presented at the time of survey, the organization could not substantiate that all departments and services were monitored by the QAPI program including contract services. Specifically, the organization had defined metrics for the following services, however the quality of the service provided was not reviewed and reported through the QAPI program.
• Nutrition Services
• Infection Control Practices
• Sonoma Valley Hospital Hand and Physical Therapy (Location #2)
• Environmental Services
• Mission Linens (Laundry services)
• Anesthesia Consultants by Marin (Anesthesia Services)
• Marti by Cloudbreak (Translation Services)

Actual / Potential Outcome: Lack of review and reporting could result in inadequate monitoring of services provided.
Individual(s) Involved: None
Information Source: Contract evaluation form, discussion with staff #1
Finding Confirmed by: Staff #1

Action Plan

Action #1
The findings were reviewed with the Chief Executive officer on 4/27/23 who directed the action plan be developed.
Actual/Potential Outcome- Lack of review and reporting could result in inadequate monitoring of the services provided

Action Plan

Overall Responsibility- Director Of Quality
Date implemented 6.1.23
Nutrition services, Infection control practices, Hand and Physical therapy, Environmental services, Mission Linens, Anesthesia services and Translation services will have defined quality metrics that will be reported through the QAPI program

Corrective Action 1

Individual quality metrics for those services noted and from all departments will be formulated and reported to the PI committee monthly and board Quality on a quarterly basis.
Date: 6.1.23
Title: The finding was reviewed by Director of Quality.

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Department/Contractor Quality Metrics
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Director of Quality
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

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Deficiency #04

Level: Standard–Level
QA-02: Collection & Use of Data
Requirement: A

The standard was not met as evidenced by the following

REQUIREMENT A
Observed during Survey Activity (Location #1) – 4/20/23 @ approximately 1500 by A. Martin
Finding: Based on information presented at the time of survey, the organization could not substantiate that high-volume, problem-prone processes are consistently monitored for outcomes. Specifically, issues were identified with non-compliance with hand hygiene practices during observation of care. There was no evidence that the organization was aware of this problem-prone area. Hand hygiene was not monitored by the QAPI program, and the organization was unaware of the non-compliance prior to the survey.
Actual / Potential Outcome: Failure to monitor problem-prone processes can delay corrective interventions and may contribute to patient safety.
Individual(s) Involved: Leadership
Information Source: Discussion with staff #24, observation of care.
Finding Confirmed by: Staff #1

Action Plan

Action #1
The findings were reviewed with the Chief Executive officer on 4/27/23 who directed the action plan be developed.
Actual/Potential Outcome- Failure to monitor problem-prone processes can delay corrective interventions and may contribute to patient safety

Action Plan

Overall Responsibility- Director Of Quality
Date implemented 6.1.23
Problem Prone areas including Hand Hygiene compliance will be monitored, analyzed and reported to the PI committee.

Corrective Action 1
Date: 6.1.23
Title: Director of Quality
Weekly audits of hand hygiene compliance will occur in all hospital departments and compliance reported to PI committee monthly and board Quality on a quarterly basis.

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Hand Hygiene Compliance
What is the sample size: 50
What is the threshold of compliance: 90%
How frequently will monitoring occur: Weekly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Director of Quality
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

Action #2
The findings were reviewed with the Chief Executive officer on 4/27/23 who directed the action plan be developed.
Actual/Potential Outcome- Failure to monitor problem-prone processes can delay corrective interventions and may contribute to patient safety

Action Plan
Overall Responsibility- Director Of Quality
Date implemented 6.1.23
Problem Prone areas including Hand Hygiene compliance will be monitored, analyzed and reported to the QAPI committee.

Corrective Action 2
Date: 6.1.23
High risk/problem prone areas will be monitored, analyzed and report monthly to the PI committee and Board Quality on a quarterly basis.

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: High risk/problem prone areas
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Director of Quality
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

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Deficiency #05

Level: Standard–Level
MS-07: Resources to Support Privileges
Requirement: A
The standard was not met as evidenced by the following
REQUIREMENT A
In 2 of 10 files, the following was noted
Observed during the Medical Staff Credential File Review Session (Location #1) – 4/21/23 @ approximately 1015 by A. Martin
Finding: The file of a General Surgeon (A.A.) last appointed on 9/2/21 was reviewed. It was noted that privileges to perform circumcisions, Nissen fundoplication's, pancreatectomy, and splenectomies had been granted. The organization does not have the space, equipment, supplies, and policies necessary to effectively support these clinical privileges.
Actual / Potential Outcome: The organization lacks the infrastructure to support the privileges granted to the practitioner.
Individual(s) Involved: Medical Staff
Information Source: Practitioner files
Finding Confirmed by: Staff #1 and #21

Observed during the Medical Staff Credential File Review Session (Location #1) – 4/21/23 @ approximately 1020 by A. Martin
Finding: The file of a Gynecologist (D.A.) last appointed on 8/4/22 was reviewed. It was noted that privileges to perform circumcisions, C- sections, hysterectomies, reconstructive pelvic surgery, and vulvectomies had been granted. The organization does not have the space, equipment, supplies, and policies necessary to effectively support these clinical privileges.
Actual / Potential Outcome: The organization lacks the infrastructure to support the privileges granted to the practitioner.
Individual(s) Involved: Medical Staff
Information Source: Practitioner files
Finding Confirmed by: Staff #1 and #21

Action Plan

Action #1
The findings were reviewed with the Chief Medical Officer on 4.27.23 who directed the following action plan to be developed.
Actual/potential outcome- The organization lacks the infrastructure to support the privileges granted to the practitioner.

Action Plan
Chief Medical Officer
Medical Staff Coordinator and the Surgery Department Chair will revise the surgical privileges to reflect the current capabilities and procedures done at Sonoma Valley Hospital. The Obstetrics privileges will be retired and removed for all providers.

Corrective Action 1
Title: Chief Medical Officer
Date: May 24,2023
Description: The finding was reviewed by the chief medical officer and Med Staff Coordinator and the privileges were revised to reflect the current capabilities at the organization. The revised privileges will be approved by the medical staff at the surgery committee on 5.11.23 and then sent to Medical Executive committee for approval on 5.18.23 and to Board Quality on 5.24.23

Title of Person Responsible for Implementing the Action: Chief Medical Officer
Date Action Plan was or will be Implemented: 5/24/2023
Is a Monitoring Plan Required?: No

Action #2
The findings were reviewed with the Chief Medical Officer on 4.27.23 who directed the following action plan to be developed.
Actual/potential outcome- The organization lacks the infrastructure to support the privileges granted to the practitioner.

Action Plan
Chief Medical Officer
Medical Staff Coordinator and the Surgery Department Chair will revise the surgical privileges to reflect the current capabilities and procedures done at Sonoma Valley Hospital. The Obstetrics privileges will be retired and removed for all providers.

Corrective Action 2 Title: Chief Medical Officer
Date: May 25, 2023
Description: Chief Medical Officer will disseminate this information and educate the appropriate medical staff about this change to the privileges.

Title of Person Responsible for Implementing the Action: Chief Medical Officer
Date Action Plan was or will be Implemented: 5/25/2023
Is a Monitoring Plan Required?: No

Deficiency #06

Level: Standard–Level
MS-09: Provision of Telemedicine Services by a Distant Site
Requirement: C

The standard was not met as evidenced by the following

REQUIREMENT C
In 2 of 10 files, the following was noted
Observed during the Medical Staff Credential File Review Session (Location #1) – 4/21/23 @ approximately 1045 by A. Martin
Finding: The file of a Tele neurologist (B.L.) and a Tele Infectious Disease practitioner (A.D.) each last appointed on 2/22/22 were reviewed. It was noted that the organization accepts the privileging decisions from the distant site entity to be approved by the governing body. However, a request was made to staff #21 to provide a list of privileges provided by the contracted entity for each practitioner. The privilege list was not provided prior to the end of survey. Hence the organization could not substantiate that it is in compliance with the standard.
Actual / Potential Outcome: The list of privileges was not provided.
Individual(s) Involved: Medical Staff

Information Source: Practitioner files
Finding Confirmed by: Staff #1 and Staff #21

Action Plan

Action #1
The findings were reviewed with the Chief Medical Office on 4.27.23 r who directed the following action plan to be developed.
Actual/Potential outcome: The list of privileges was not provided

Action Plan
Chief Medical Officer
Med staff coordinator will obtain the current privileges for all of the telehealth ID and telehealth Neurology providers and keep this record updated at each reappointment.

Corrective Action 1
Title: Chief Medical Officer
Date: May 2, 2023
Description: The finding was reviewed by the CMO and Medical Staff Coordinator. The MSC obtained the list of current privileges for all telehealth Neurology and ID physicians and added to credentialing files These privileges will be reviewed and updated at the initial appointment or each reappointment.

Title of Person Responsible for Implementing the Action: Chief Medical Officer
Date Action Plan was or will be Implemented: 5/2/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Medical Staff Privileges
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Chief Medical Officer
What committee in the QAPI program will receive reports on the results: Medical Executive Committee and Board Quality

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Deficiency #07

Level: Standard–Level
CE-01: Provision of Facilities
Requirement: A

The standard was not met as evidenced by the following

REQUIREMENT A
Observed during the Building Tour of the Emergency Department N-118 (Location #1) – 4/18/23 @ approximately 1410 by R. Cole
Finding: During a tour of the environment, it was noted that the eye-wash station located in the Emergency Department did not meet the requirements of ANSI Z358.1. Specifically, the operation of the eye wash takes two motions to activate.
Actual / Potential Outcome: Non-compliance with ANSI eye wash requirements could result in harm to staff. Individual(s)
Involved: Facilities staff
Information Source: Direct observation of the surveyor
Finding Confirmed by: Staff #5

Action Plan

Action #1
The findings were reviewed with Chief of Support Services and Plant Operations Manager during an in-person meeting on 4.27.23 who directed the action plan be developed.
All staff are at risk for the following deficiency:
Eye wash station located in the Emergency Department did not meet the requirements of ANSI Z358.1 and takes 2 motions to activate.
Actual/potential outcome: Non-compliance with ANSI eye was requirements could result in harm to staff

Action Plan
Chief of Support Services
Eye wash station in the Emergency Department will be replaced with a single action model.

Corrective Action 1
Date: 5/5/23
Work Order 253644: Single action eye was station was ordered on 4/26/23 and will be installed by 5/5/23.

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/5/2023
Is a Monitoring Plan Required?: No

Action #2
Corrective Action 2
Date: 5/22/23
Work order 253670: All eye wash stations will be surveyed in the facility to ensure that they comply with single motion activation. This survey will be completed by 5/5/23. Any non-complying eye wash stations that are identified will be replaced by 5/22/23 with single action models.

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/22/2023
Is a Monitoring Plan Required?: No

Deficiency #08

Level: Standard–Level
CE-03: Provision of a Safe Environment
Requirement: A

The standard was not met as evidenced by the following

REQUIREMENT A
Observed in the Medical Surgical Unit (Location #1) – 4/18/23 @ approximately 1045 by A. Martin
Finding: During a tour of the environment, it was noted that an emergency call light cord was wrapped around the grab bar in a patient bathroom in room #317.
Actual / Potential Outcome: This would potentially prevent the pull cord from being used to activate a nurse call alarm when needed.
Individual(s) Involved: NA
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #2

Action Plan

Action #1
The findings were reviewed with the Chief Nursing officer on 4.27.23 who directed the action plan to be developed.
Finding: During a tour of the environment, it was noted that an emergency call light cord was wrapped around the grab bar in a patient bathroom
Actual / Potential Outcome: This would potentially prevent the pull cord from being used to activate a nurse call alarm when needed. Patients are at risk for the deficient practice
Action Plan
Overall responsibility: Chief Nursing Officer Director of Patient Care; Follow up by Assistant Nurse Manager
Completion Date: 5/31/2023
Description: Patient bathrooms will be made safe by ensuring all patients can easily access the emergency/assistance pull cord.
Corrective Action 1 - Email communication to EVS leadership 4/27/23 regarding room set up upon terminal clean.

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 4/27/2023
Is a Monitoring Plan Required?: No

Action #2
Corrective Action 2 - Discussion during staff meeting on 4/28/23 of finding and reason for leaving cord free from grab bar. Attestation signed

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: No

Action #3
Corrective Action 3 - Email of minutes from meeting sent 4/28/23 to all RN, CNA and UA staff as well as placed in ICU and MS Huddle binder. Attestation signed

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: No

Action #4
Corrective Action 4 - 5.31.23 Visual auditing of 10 random patient rooms weekly for one month, then monthly for 6 months. Goal 100% compliance

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Pull Cord Compliance
What is the sample size: 10
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Chief Nursing Officer
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

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Deficiency #09
Level: Standard–Level
CE-07: Management of Hazardous Materials & Waste
Requirement: F
The standard was not met as evidenced by the following
REQUIREMENT F
Observed in the Imaging Department (Location #1) – 4/19/23 @ approximately 1015 by A. Martin
Finding: During a tour of the environment, it was noted that there was no spill kit in the location where formalin is used in the procedure room.
Actual / Potential Outcome: Lack of a spill kit could delay an appropriate response to managing the spill.
Individual(s) Involved: Ultrasound staff
Information Source: Direct observation by surveyor, discussion with staff #13
Finding Confirmed by: Staff #9

Action Plan
Action #1
The findings were reviewed with Chief of Support Services and Plant Operations Manager during an in-person meeting who directed the action plan be developed.
All staff, patients and visitors are at risk for the following deficiency:
It was noted that there was no spill kit in the location where formalin is used in the procedure room.
Actual/potential outcome: Lack of a spill kit could delay an appropriate response to managing the spill.
Action Plan
Chief, Support Services
Spill kits will be placed in all locations where formalin is used.
Corrective Action 1
Date: 5/10/23
Work Order 253671: Survey of all locations utilizing formalin to ensure a spill kit and protective equipment is in close proximity for spill response. Order any needed spill kits and place in locations utilizing formalin by 5/22/23. Train users on use of spill kit and notification protocols by 5/22/23. New employees training by Department Leader as part of department orientation.

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/22/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Presence of a complete spill kit wherever formalin is us
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: ongoing

Who will oversee the monitoring: Chief of Support Services
What committee in the QAPI program will receive reports on the results: Safety Committee, Board Quality Committee

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Deficiency #10

Level: Standard–Level
CE-09: Management of Supplies
Requirement: B

The standard was not met as evidenced by the following

REQUIREMENT B

Observed in the PACU (Location #1) – 4/18/23 @ approximately 1335 by A. Martin
Finding: During a tour of the environment, it was noted that a package of Kendall EKG electrodes was found open and not dated with an adjusted expiration date in the PACU bay. Per manufacturer's instructions, the electrodes are functional for 45 days. Staff were unable to validate when the electrodes had been opened.
Actual / Potential Outcome: Use of open electrodes past the expiration date has the potential to cause faulty conduction and adversely affect the quality of the ECG tracing.
Individual(s) Involved: Surgical staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #8

Observed in the OR (Location #1) – 4/18/23 @ approximately 1340 by A. Martin
Finding: During a tour of the environment, it was noted that a package of Medline electrodes was found open and not dated with an adjusted expiration date on the anesthesia cart in OR#2. Per manufacturer's instructions, the electrodes are functional for 45 days. Staff were unable to validate when the electrodes had been opened.
Actual / Potential Outcome: Use of open electrodes past the expiration date has the potential to cause faulty conduction and adversely affect the quality of the ECG tracing.
Individual(s) Involved: Surgical staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #8

Observed in the ICU (Location #1) – 4/18/23 @ approximately 1115 by A. Martin
Finding: During a tour of the environment, it was noted that a bottle of ECO lab hand sanitizer was found expired as of March 2022, and was still available for use in the medication prep area.
Actual / Potential Outcome: Expired hand sanitizer was not removed from active inventory.
Individual(s) Involved: ICU staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #3

Observed in the ICU (Location #1) – 4/18/23 @ approximately 1120 by A. Martin
Finding: During a tour of the environment, it was noted that a foam enzymatic spray bottle was found expired as of 9/10/21 and available for use in the biohazard room.
Actual / Potential Outcome: Enzymatic spray used to disinfect reusable instruments was expired.
Individual(s) Involved: ICU staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #3

Observed in the Emergency Department (Location #1) – 4/19/23 @ approximately 1130 by A. Martin
Finding: During a tour of the environment, it was noted that clean supplies were found stored in biohazard bags in several patient care rooms. In addition, ECG electrodes were found stored in a biohazard bag on the vital sign machine.
Actual / Potential Outcome: Biohazardous bags must only be used to communicate biohazardous contents. Individual(s) Involved: Emergency Department staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #14

Action Plan

Action #1
The findings were reviewed with the Chief Nursing officer and the Chief of Support Services on 4.27.23 , who directed the action plan to be developed.

Actual/Potential Outcome:

- Use of open electrodes past the expiration date has the potential to cause faulty conduction and adversely affect the quality of the ECG tracing;
- Biohazardous bags must only be used to communicate biohazardous contents

- Enzymatic spray used to disinfect reusable instruments was expired
- Expired Hand Sanitizer was not removed from active inventory

Action Plan

Overall responsibility: Chief Nursing Officer and Chief of Support Services. Follow up by Director of Patient Care Services, Director of Emergency Services, Surgical Services Manager

Corrective Action 1: Date 4.18.23

All expired Items were removed and discarded. 4.18.23

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 4/18/2023
Is a Monitoring Plan Required?: No

Action #2

Corrective Action 2: Date 4.18.23

New enzymatic spray product obtained and replaced on 4.18.23

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 4/18/2023
Is a Monitoring Plan Required?: No

Action #3

Corrective Action 3. Date: 4/18/23

EVS Manager surveyed entire Facility to ensure that expired hand sanitizer was not in use. EVS Manager surveyed stored supplies to ensure there was not any hand sanitizer in stock that was expired or within 3 months of expiration.

Title of Person Responsible for Implementing the Action: Materials Management Director
Date Action Plan was or will be Implemented: 4/18/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Expiration on Hand Sanitizer stored supplies
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Materials Management Director
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

Action #4

Corrective Action 4- Date 4.28.23

Discussion during staff meetings on 4/28/23 of finding and reason for removing expired product; Email of minutes from meeting sent 4/28/23 to all RN, CNA and UA staff as well as placed in ICU and MS Huddle binder. Attestation signed

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: No

Action #5

Corrective Action 5: Date 6.1.23

Educate staff in all patient care departments on "shelf life" of EKG electrodes. Attestation signed

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: No

Action #6

Corrective Action 6: Date 6.1.23

Instruct staff to write expiration date 30 days from date of opening on all packages of EKG electrodes.

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: No

Action #7
Corrective Action 7: Date 6.1.23
Supply audit of all opened packages of EKG electrodes in patient care areas to be completed by unit Directors/Managers; weekly for one month, then monthly for 6 months

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Opened EKG Electrodes dated
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Chief Nursing Officer
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

Action #8
Corrective Action 8: 6.1.23
Supply audit of stored items to ensure no supplies are stored in biohazardous bags to be completed by unit Directors/Managers; weekly for one month, then monthly for 6 months. Goal: 100% compliance

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Appropriate Storage of Supplies
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Chief Nursing Officer
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

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Deficiency #11
Level: Standard–Level
CE-11: Ventilation, Lighting & Temperature Control
Requirement: C
The standard was not met as evidenced by the following
REQUIREMENT C
Observed during Document Review (Location #1) – 4/19/23 @ approximately 1230 by A. Martin
Finding: Based on information presented at the time of survey, the organization could not substantiate that daily temperature and humidity readings were being maintained as required by ASHRAE 170-2008. Specifically, the operating room logs reviewed for January 2023 – April 2023 were missing weekend temperature and humidity readings. In discussion with staff #8 there is not a process in place to monitor and document temperature and humidity on weekends and holidays when the facility is closed.
Actual / Potential Outcome: Temperature and humidity readings were not being monitored daily.
Individual(s) Involved: OR staff
Information Source: Surgery daily temperature and humidity logs
Finding Confirmed by: Staff #6

Observed during Document Review (Location #1) – 4/19/23 @ approximately 1240 by A. Martin
Finding: Based on information presented at the time of survey, the organization could not substatiate that daily temperature readings were maintained as required by ASHRAE 170-2008. Specifically, daily temperature readings for the sterile storage areas and the decontamination room were predominately documented as below 72°F during the months of January 2023, February 2023, March 2023, and April 2023. There were no documented actions taken or subsequent monitoring to assure that the temperature

returned within the acceptable range for all the dates the areas were out of range.
Actual / Potential Outcome: Equipment exposed to variations in temperature may become a source of infection. Individual(s) Involved: Facilities staff
Information Source: Surgery daily rounding temperature, and humidity sheets
Finding Confirmed by:
Staff #1

Observed in the Rehab Clinic (Location #2) – 4/19/23 @ approximately 1340 by A. Martin
Finding: During a tour of the environment, it was noted that reusable sterilized instruments are being stored in the cabinets. Based on discussion with staff the instruments are used for skin debridement by the occupational hand specialist. In further discussion with staff the organization does not have a process in place to monitor daily temperature and humidity as required by ASHRAE 170-2008.
Actual / Potential Outcome: Temperature and humidity was not being monitored where sterile instruments are stored. Individual(s) Involved: Rehab staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #17

Action Plan

Action #1
The findings were reviewed with Chief Nursing Officer and Chief of Support Services during an in-person meeting on 4.27.23 who directed the action plan be developed.
All staff, patients and visitors are at risk for the following deficiencies:

- OR temperature and humidity readings were not being monitored daily.
- Equipment exposed to variations in temperature may become a source of infection
- Temperature and humidity were not being monitored where sterile instruments are stored.

Action Plan
Chief Nursing Officer; Chief Support Services;
Ensure temperature and humidity reading process for Temp/Humidity is monitored 7 days per week.
Corrective Action 1 Date: 4/19/23
Sterile storage and decontamination room monitoring logs range guidance were corrected to reflect the correct temperature and humidity per ASHRAE standards. All staff were notified of the new range and to notify Engineering if temperature or humidity are outside this acceptable range. Attestation signed

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 4/19/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: All temperature and humidity logs
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Weekly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Chief of support services
What committee in the QAPI program will receive reports on the results: Performance Improvement, Board Quality

Action #2
Corrective Action 2 Date: 4/28/23
Engineering staff notified to document on the monitoring log that temperature and humidity have been returned to an acceptable range in addition to documentation on their work order. Attestation signed.

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 4/28/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: All temperature and humidity logs
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Weekly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Chief of Support Services

What committee in the QAPI program will receive reports on the results: Performance Improvement, Board Quality

Action #3

Corrective Action 3

Date 5.1.23

If Sterile equipment is needed in departments where temperature and humidity logs are not being monitored, equipment will be requested day of need from Central Sterile and not stored in the department

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/1/2023
Is a Monitoring Plan Required?: No

Action #4

Corrective Action 4 Date: 5/5/23

Respiratory Therapist will record temperature and humidity for each OR, Surgery Sterile Storage and Decontamination room on Saturday and Sunday. If temperature or humidity is out of range, the Nursing Supervisor will be notified to call the Engineer-on-call to request corrective action to bring them into acceptable range.

Title of Person Responsible for Implementing the Action: Chief of Support Services, Chief Nursing Officer
Date Action Plan was or will be Implemented: 5/5/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: All temperature and humidity logs
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Weekly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Chief of Support Services
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

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Deficiency #12

Level: Standard–Level
CE-13: Testing of Emergency Power Systems
Requirement: H

The standard was not met as evidenced by the following

REQUIREMENT H

Observed during Document Review (Location #1) – 4/18/23 @ approximately 1000 by R. Cole

Finding: The organization was asked to produce evidence that they are performing a monthly conductance test on the generator maintenance free batteries. In an interview with Staff #5 it was determined that conductance testing was not performed. Hence, the organization could not substantiate that it is in compliance with this standard.
Actual / Potential Outcome: Failure to perform a conductance test could result in the organization being unaware of any deficiencies.
Individual(s) Involved: Facilities staff.
Information Source: None
Finding Confirmed by: Staff #5

Action Plan

Action #1

The findings were reviewed with Chief of Support Services and Plant Operations Manager during an in-person meeting 4/27/23 who directed the action plan be developed.
Actual/Potential outcome: Failure to perform the test could result in the Facility being unaware of a faulty battery which could impact the generator's ability to start when expected.

Action Plan

Overall responsibility: Chief, Support Services.
Begin testing batteries during monthly generator test as of 6/7/23.

Corrective Action 1 Work Order 253646: Research and purchase battery conductance tester for maintenance free batteries by ***6/1/2023***

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 6/7/2023
Is a Monitoring Plan Required?: No

Action #2
The findings were reviewed with Chief of Support Services and Plant Operations Manager during an in-person meeting 4/27/23 who directed the action plan be developed.
Actual/Potential outcome: Failure to perform the test could result in the Facility being unaware of a faulty battery which could impact the generator's ability to start when expected.
Corrective Action 2 Date: 6/7/23 log results during monthly generator test which occurs the 1st Wednesday of the month.

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 6/7/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Generator Batteries charge
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: ongoing
Who will oversee the monitoring: Manager of Plant Operations
What committee in the QAPI program will receive reports on the results: Board Quality Committee

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Deficiency #13

Level: Standard–Level
CE-15: Compliance to the NFPA Life Safety Code
Requirement: A
The standard was not met as evidenced by the following
REQUIREMENT A
Observed during the Building Tour of the Electrical Room E-131 (Location #1) – 4/18/23 @ approximately 1420 by R. Cole
Finding: During a tour of the environment, it was noted that an inventory list of all the sprinkler heads installed in the building was not posted inside the spare sprinkler cabinet. This is a violation of NFPA 13-2010 6.2.9.7.
Actual / Potential Outcome: Non-compliance with NFPA codes could adversely affect the fire safety of buildings and occupants.
Individual(s) Involved: Facilities staff.
Information Source: Direct observation of the surveyor
Finding Confirmed by: Staff #5

Observed during the Building Tour of Materials Management (Location #1) – 4/18/23 @ approximately 1440 by R. Cole
Finding: During a tour of the environment, it was noted that wires were being supported to the sprinkler piping in 3 separate locations inside Materials Management. This is a violation of NFPA 25-2011 5.2.2.2.
Actual / Potential Outcome: Sprinkler piping is not permitted to support any items. Individual(s)
Involved: Facilities staff.
Information Source: Direct observation of the surveyor
Finding Confirmed by: Staff #5

Observed during the Building Tour of the Emergency Department (Location #1) – 4/18/23 @ approximately 1400 by R. Cole
Finding: During a tour of the environment, it was noted that oxygen cylinders and storage racks were blocking the fire alarm manual pull station in the ambulance bay exit. This is a violation of NFPA 72-2010 17.14.5.
Actual / Potential Outcome: Staff must be able to access a fire alarm pull station in the event of
an emergency. Individual(s) Involved: Emergency Department staff.
Information Source: Direct observation of the surveyor
Finding Confirmed by: Staff #5

Observed during the Building Tour of the Main Lobby (Location #1) – 4/18/23 @ approximately 1345 by R. Cole
Finding: During a tour of the environment, it was noted that exit signs were not visible and were not installed properly in the main lobby. A paper sign was attached to the door showing the direction of the exit towards the Emergency Department. The paper sign did not meet the requirement of a properly installed exit sign. This is a violation of NFPA 101-2012 7.10.1.2.
Actual / Potential Outcome: Non-compliance with NFPA codes could adversely affect the fire safety of buildings and occupants.
Individual(s) Involved: Facilities staff.
Information Source: Direct observation of the surveyor

Finding Confirmed by: Staff #5

Observed during the Building Tour of the 2nd floor (Location #1) – 4/18/23 @ approximately 1345 by R. Cole
Finding: During a tour of the environment, it was noted that panic hardware was installed where fire exit hardware is required. Specifically, the hardware was installed on the 90-minute fire rated door to the exit stair door #025617.
Actual / Potential Outcome: Non-compliance with NFPA codes could adversely affect the fire safety of buildings and occupants.
Individual(s) Involved: Staff #5
Information Source: Direct observation of the surveyor
Finding Confirmed by: Staff #5

Observed during the Building Tour of the 2nd floor (Location #1) – 4/18/23 @ approximately 1345 by R. Cole
Finding: During a tour of the environment, it was noted that the suite doors from the PACU to the corridor, # 026017, did not close and latch. This is a violation of NFPA 101-2012 19.2.5.7.1.2.
Actual / Potential Outcome: Doors to a suite are required to meet corridor door requirements which requires them to latch.
Individual(s) Involved: Facilities staff.
Information Source: Direct observation of the surveyor
Finding Confirmed by: Staff #5

Observed during the Building Tour of the 3rd floor (Location #1) – 4/18/23 @ approximately 1300 by R. Cole
Finding: During a tour of the environment, it was noted that the suite doors from the ICU to the corridor, # 025627, did not close and latch. The coordinator to allow the doors to close properly did not function. This is a violation of NFPA 101-2012 19.2.5.7.1.2.
Actual / Potential Outcome: Barrier doors must be functioning properly to ensure they will work as designed when needed during an emergency.
Individual(s) Involved: Facilities staff.
Information Source: Direct observation of the surveyor
Finding Confirmed by: Staff #5

Action Plan

Action #1
The findings were reviewed with Chief of Support Services and Plant Operations Manager during an in-person meeting 4/27/23 who directed the action plan be developed._
Overall responsibility: All NFPA life safety code deficiencies identified during the building tour will be corrected by 6/23/23. All deficiency corrections that are performed by the Facility will be completed by 5/31. Work that is completed by vendors or require difficult to source parts or in depth documentation will be completed by 6/23.
Not having an inventory list of all sprinkler heads installed in the building as required by NFPA codes could impact the fire safety of the building and the occupants.
Corrective Action 1: Date 6.23.23
Work order: 253647 Create an inventory list of all sprinkler heads and types installed in the building and post inside the spare sprinkler cabinet.

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 6/23/2023
Is a Monitoring Plan Required?: No

Action #2
Wires being supported by a sprinkler pipe could compromise the integrity of the sprinkler Infrastructure and impact the fire safety of the building and the occupants.
Corrective Action 2: Date 5.19.23
Work order 253648: Relocate wires from 3 locations supported by sprinkler piping to be supported in a compliant manner.

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/19/2023
Is a Monitoring Plan Required?: No

Action #3
Having any items in front of a fire alarm pull station can impact all occupant's ability to pull the fire alarm in the event of an emergency.
Corrective Action 3: Date 5.5.23
Work order 253649: Relocate oxygen cylinders and storage racks away from manual pull station to a compliant location.

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/5/2023
Is a Monitoring Plan Required?: No

Action #4
Not having lighted, visible exit signs in the Main Lobby could impact all occupant's ability to exit the building safely in the event of an emergency
Corrective Action 4: Date 5.1.23
Work order 252423: 2 exit signs ordered 4/21/23 and installed on 5/1/23.

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/1/2023
Is a Monitoring Plan Required?: No

Action #5
Not having the proper exit hardware on the exit stairwell door could impact all occupant's ability to safely access the emergency exits in the event of an emergency.
Corrective Action 5: Date 6.5.23
Work order 253650: Source appropriate fire exit hardware for exit stairwell door #025617 to replace the panic hardware.

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 6/5/2023
Is a Monitoring Plan Required?: No

Action #6
Corridor doors in the PACU not properly latching could allow for the transference of smoke and impact fire safety of the building and the occupants.
Corrective Action 6: Date 6.16.23
Work order 253651: 4.28.23 Stanley Access Technologies has been engaged to order missing parts for PACU door 025627 to allow it to latch.

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 6/16/2023
Is a Monitoring Plan Required?: No

Action #7
Suite doors in the ICU not properly closing and latching could allow for the transference of smoke and impact fire safety of the building and the occupants.
Corrective Action 7: Date 5.31.23
Work order 253652: Remove existing smoke barrier and install brushes on door seam to allow for smoke barrier compliance. Installation of brushes allow for the removal of the malfunctioning door sequencer. Doors will close together upon activation of fire alarm.

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: No

Deficiency #14

Level: Standard–Level
CE-15: Compliance to the NFPA Life Safety Code
Requirement: D
The standard was not met as evidenced by the following
REQUIREMENT D
Observed during Document Review (Location #1) – 4/18/23 @ approximately 0905 by R. Cole
Finding: Based on information presented at the time of survey, the organization did not provide a set of current and accurate fire and life safety drawings. Specifically, the drawings provided were dated 2013 and did not show changes to OR Suite #1, ED Suite #3, and 3rd floor L&D. Hence, the organization could not substantiate that it is in compliance with this standard.
Actual / Potential Outcome: Current life drawings are required to ensure that proper fire protection is in place and surveyors have the ability to perform an accurate life safety assessment.
Individual(s) Involved: Facilities staff.

Information Source: Life Safety Drawings Dated 2013 as presented.
Finding Confirmed by: Staff #5

Action Plan

Action #1
The findings were reviewed with Chief of Support Services and Plant Operations Manager during an in-person meeting 4/27/23 who directed the action plan be developed.
Current fire and life safety drawings with correct labeling are necessary for accurate life safety assessments.
Corrective Action 1: Date 6.26.23
5.3.23 Facility engaged SKA Architects to update fire and life safety drawings for the New Wing and Main Hospital.

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/3/2023
Is a Monitoring Plan Required?: No

Action #2
SKA Architects have committed to complete the UPDATED drawings by 6.26.23.

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 6/26/2023
Is a Monitoring Plan Required?: No

Deficiency #15

Level: Standard–Level
CE-21: Compliance to the NFPA Health Care Facilities Code
Requirement: F

The standard was not met as evidenced by the following

REQUIREMENT F
Observed in the Medical Surgical Unit (Location #1) – 4/18/23 @ approximately 1055 by A. Martin
Finding: During a tour of the environment, it was noted that the door leading into the respiratory storage room did not have signage that included "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING" where oxygen cylinders were being stored. This is a violation of NFPA 99-2012, 11.3.4.2.
Actual / Potential Outcome: Improper signage can decrease occupants' awareness to potentially dangerous conditions.
Individual(s) Involved: Facility staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #6

Observed in the Cardiopulmonary Department (Location #1) – 4/19/23 @ approximately 0950 by A. Martin
Finding: During a tour of the environment, it was noted that the door leading into the clean supply room did not have signage that included "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING" where oxygen cylinders were being stored. This is a violation of NFPA 99-2012, 11.3.4.2.
Actual / Potential Outcome: Improper signage can decrease occupants' awareness to potentially dangerous conditions.
Individual(s) Involved: Facility staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #9

Observed in the Pulmonary Function Testing Room (Location #1) – 4/19/23 @ approximately 1005 by A. Martin
Finding: During a tour of the environment, it was noted that a gas cylinder was not properly secured in place to keep it from accidental damage. Specifically, an "E" cylinder was laying on the floor and not secured by a chain or support bracket in the treatment room. This is a violation of NFPA 99-2012, 11.6.2.3(11).
Actual / Potential Outcome: Unsecured gas cylinders could adversely affect the safety of the building and occupants.
Individual(s) Involved: PFT staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #12

Action Plan

Action #1
The findings were reviewed with Chief of Support Services and Plant Operations Manager during an in-person meeting 4/27/23 who directed the action plan be developed.
Corrective Action 1: Date 4.28.23
Lead Engineer surveyed Facility to ensure no other locations required signage for oxygen.

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 4/28/2023
Is a Monitoring Plan Required?: No

Action #2
Work order: 253653 Affix signage on respiratory storage room "CAUTION: OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING"

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/3/2023
Is a Monitoring Plan Required?: No

Action #3
Work order 253654: Affix signage on Cardiopulmonary clean supply room "CAUTION: OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING"

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/3/2023
Is a Monitoring Plan Required?: No

Action #4
Corrective Action 4: Date 5.5.23
Work order 252655: Secure cylinder with a chain in Pulmonary Function Testing ("PFT") room. Educate PFT technician to not have a spare cylinder in room unsecured and remove empty cylinder to appropriate storage rack when changing the cylinder. Attestation signed

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/5/2023
Is a Monitoring Plan Required?: No

Deficiency #16

Level: Standard–Level
IC-03: Infection Prevention & Control Policies
Requirement: A
The standard was not met as evidenced by the following
REQUIREMENT A
Observed in the Medical Surgical Unit (Location #1) – 4/18/23 @ approximately 1100 by A. Martin
Finding: During a tour of the environment, it was noted that several infection control concerns were observed throughout the medical surgical unit. Specifically,

- There was chipped and peeling laminate on the bed table in patient room #317. Exposed raw wood cannot be adequately disinfected between patients.
- There was vinyl that was torn on two (2) visitor cots stored in the clean supply room. Exposed vinyl cannot be adequately disinfected.
- There was a significant amount of calcification on the downspout inner surfaces of the ice/water machine. Microorganisms can harbor in the calcification and could potentially be transmitted through the water supply to patients and staff.
- There was dust and debris in bins containing clean opened supplies in the respiratory supply room

Actual / Potential Outcome: Failure to maintain clean equipment and environment may transmit microorganisms which potentially compromise the safety of patients and staff.
Individual(s) Involved: Environmental services, Clinical care staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #2

Observed in the ICU (Location #1) – 4/18/23 @ approximately 1145 by A. Martin
Finding: During a tour of the environment, it was noted several infection control concerns were observed throughout the ICU unit. Specifically,

- There was a chair with torn vinyl in ICU room #1. Exposed vinyl cannot be adequately disinfected.
- There was furniture with exposed raw wood throughout the unit. Exposed raw wood cannot be adequately disinfected.
- There was trash in a garbage can, specimen cup in the biohazard bin and dirty linen in a bin located in a clean patient room #1.
- There was a significant amount of calcification on the downspout inner surfaces of the ice/water machine. Microorganisms can harbor in the calcification and could potentially be transmitted through the water supply to patients and staff.

Actual / Potential Outcome: Failure to maintain clean equipment and environment may transmit microorganisms which potentially

compromise the safety of patients and staff.
Individual(s) Involved: Environmental services, Clinical care staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #3

Observed in the Rehabilitation Facility (Location #2) – 4/19/23 @ approximately 1345 by A. Martin
Finding: During a tour of the environment, it was noted that several infection control concerns were observed throughout the rehabilitation facility. Specifically,

- There was dust and debris throughout the rehab gym floors and supply rooms.
- There was a significant amount of dust on the rehab equipment such as exercise bikes, and treadmills.
- There was dust and dirt on the ultrasound machine and reusable balance devices.
- There were wood handles used for occupational therapy with tape that was visibly dirty. Tape cannot be adequately disinfected between patients.
- There were several rehab devices that were made from Styrofoam that are used between patients and were visibly dirty. Styrofoam cannot be adequately disinfected between patients.

Actual / Potential Outcome: Failure to maintain clean equipment and environment may transmit microorganisms which potentially compromise the safety of patients and staff.
Individual(s) Involved: Environmental services, Rehab staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #17

Observed in the OR (Location #1) – 4/18/23 @ approximately 1400 by A. Martin
Finding: During a tour of the environment, it was noted that there were four (4) oral airways out of their original packaging and available for use in the anesthesia cart in OR#2. Specifically, Staff #8 was unable to determine if the supplies were clean or dirty.
Actual / Potential Outcome: Use of single use patient care supplies on multiple patients could potentially increase risk of hospital acquired infection.
Individual(s) Involved: OR staff, Anesthesia providers
Information Source: Direct observation by Surveyor
Finding Confirmed by: Staff #6

Observed in the OR (Location #1) – 4/18/23 @ approximately 1410 by A. Martin
Finding: During a tour of the environment, it was noted that there was a Valley lab metal cart that had a significant amount of peeling rust located next to the OR table in room #2.
Actual / Potential Outcome: Rust provides a harbor for microorganisms and is unable to be effectively cleaned between patients.
Individual(s) Involved: OR staff
Information Source: Direct observation by Surveyor
Finding Confirmed by: Staff #8

Observed in the Cardiopulmonary Department (Location #1) – 4/19/23 @ approximately 0955 by A. Martin
Finding: During a tour of the environment, it was noted that there was an exam table that had torn vinyl exposing foam in the stress testing room.
Actual / Potential Outcome: Foam cannot be adequately disinfected between patients
Individual(s) Involved: OR staff, Anesthesia providers
Information Source: Direct observation by Surveyor
Finding Confirmed by: Staff #9

Observed in the Emergency Room (Location #1) – 4/19/23 @ approximately 1155 by A. Martin
Finding: During a tour of the environment, it was noted that two (2) single-use pressure bags and multiple pediatric blood pressure cuffs that were out of their original packaging and available for use in patient treatment rooms. In discussion with staff, the bags and cuffs are wiped down with a disinfectant between patients.
Actual / Potential Outcome: Use of single use patient care supplies on multiple patients could potentially increase risk of hospital acquired infection.
Individual(s) Involved: Emergency room staff
Information Source: Direct observation by Surveyor, Med Choice, and Sun Med manufacturer's instructions for use.
Finding Confirmed by: Staff #14

Observed in the Pulmonary Function Testing Room (Location #1) – 4/19/23 @ approximately 1000 by A. Martin
Finding: During a tour of the environment, it was noted that oxygen tubing was out of its original package and available for use in the PFT room. In further discussion with staff #12, the tubing was there in case it was needed and was not able to determine if the tubing was clean or dirty.
Actual / Potential Outcome: Failure to maintain manufacturer packing allows supplies to become contaminated prior to use and/or be used

on multiple patients with the potential of causing hospital acquired infection.
Individual(s) Involved: RT staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #9

Action Plan

Action #1
The findings were reviewed with the Chief Nursing Officer, Chief Executive Officer and Chief of Support Services on 4/27/23, who directed the action plan to be developed.

Action Plan
Overall Responsibility- Chief of Support Services, Chief Nursing Officer
Date Implemented- 4.23.23
Ensure that all equipment in the environment is in good working order, maintained in a cleaned state and regular environment of care rounds occur with the Infection Preventionist, EVS Manager and departmental leadership. Routinely monitor patient care and common areas for damaged furniture. Repair furniture when damaged and/or take out of service. Deep cleaning of exterior and dispensing nozzles of all ice machine weekly.

Corrective action #1
Date: 4.19.23
Staff educated that once room is cleaned, garbage cans, biohazard bins and linen carts should not be used in cleaned/empty rooms

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 4/19/2023
Is a Monitoring Plan Required?: No

Action #10
Corrective action #10
Date: 5.15.23
EVS manager set up monthly deep clean schedule for floor/equipment cleaning for outpatient physical therapy department

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/15/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Rehab Deep Clean
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Chief of Support Services
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

Action #11
Corrective action #11
Date: 5.19.23
Work order #253675 Repair vinyl on damaged cots

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/19/2023
Is a Monitoring Plan Required?: No

Action #12
Corrective action #12
Date: 4.19.23
All single use items that have been opened have been removed and discarded

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 4/19/2023
Is a Monitoring Plan Required?: No

Action #13

Date:5.31.23
All Nursing staff will be educated on the use and storage of single use items and that they will be discarded after patient use, attestation signed.

Title of Person Responsible for Implementing the Action: Chief Nursing officer
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: No

Action #14
Corrective action #14
Date: 5.31.23
Unit managers to conduct monthly environmental audits specifically to ensure single use items are stored correctly and discarded after use

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Singe use items
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 Months of Continuous Compliance
Who will oversee the monitoring: Chief Nursing Officer
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

Action #15
Corrective action plan #15
Date: 4.19.23
Valley Lab metal Cart removed from service

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 4/19/2023
Is a Monitoring Plan Required?: No

Action #16
Corrective action plan #16
Date: 5.4.23
Request sent on 5/4/23 to Biomed to assess cart for repair, if unable to repair cart will be replaced by 6.15.23.

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 6/15/2023
Is a Monitoring Plan Required?: No

Action #17
Corrective action #17
Date: 5.5.23
Exam table was removed from use for repair

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/5/2023
Is a Monitoring Plan Required?: No

Action #2
Corrective action #2
Date: 4.23.23
EVS Floor tech deep cleaned the outpatient physical therapy floors and all equipment

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 4/23/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: All patient care areas floors
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Chief of Support Services
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

Action #3
Corrective action #3
Date: 5.2.23
Environmental rounds by Director of Quality, Infection Preventionist, EVS Manager and Rehab services manager at the Rehab Facility

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 5/2/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Environmental Rounds all departments
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Director of Quality
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

Action #4
Corrective action #4
Date: 5.2.23
Tape was removed from all equipment and Styrofoam equipment has been removed

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 5/2/2023
Is a Monitoring Plan Required?: No

Action #5
Corrective action #5
Date: 5.4.23
EVS Manager met with contracted cleaning vendor to review service level expectations and set up weekly monitoring of their staff

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/4/2023
Is a Monitoring Plan Required?: No

Action #6
Corrective Action #6
Date:5.5.23
Infection preventionist created a monitoring plan. Monthly IP surveillance and rounds to occur monthly for all hospital departments. Documentation includes infection control findings, items that need repair or removal and corrective action plan for departmental leaders

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 5/5/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan

What will be monitored: All departments environmental rounds
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Director of Quality
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

Action #7
Corrective action #7
Date: 5.5.23
EVS Manager Surveyed all units for damaged furniture and items taken out of service until it can be repaired

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/5/2023
Is a Monitoring Plan Required?: No

Action #8
Corrective action #8
Date: 5.5.23 EVS manager educated housekeeping staff to report all damaged furniture discovered on their shift. Attestation signed

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/5/2023
Is a Monitoring Plan Required?: No

Action #9
Corrective action #9
Date: 5.10.23
Remove the calcification on all ice machines utilizing a bicarbonate solution
Add deep cleaning weekly task to all housekeeper checklists to clean exterior and dispenser nozzles to keep machines free of calcification

Title of Person Responsible for Implementing the Action: Chief of Support Services
Date Action Plan was or will be Implemented: 5/10/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Ice Machines
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Weekly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Chief of Support Services
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

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Deficiency #17
Level: Condition–Level
IC-03: Infection Prevention & Control Policies
Requirement: A
The standard was not met as evidenced by the following
REQUIREMENT A
Observed in the Emergency Room (Location #1) – 4/19/23 @ approximately 1200 by A. Martin
Finding: During a tour of the environment, it was noted that BD hair clippers had hair remnants present and was available for patient use in the medication storage room. Staff #16 was unable to speak to the cleaning process.
Actual / Potential Outcome: The BD clippers were not cleaned between patients.
Individual(s) Involved: ED staff
Information Source: Direct observation by the surveyor, discussion with staff #16
Finding Confirmed by: Staff #14
THIS IS A CONDITION LEVEL DEFICIENCY
Action Plan

Action #1
The findings were reviewed with the Chief Nursing officer, Chief Executive Officer and Chief of Support Services on 4/27/23, who directed the action plan to be developed.
Actual / Potential Outcome: The BD clippers were not cleaned between patients.
CONDITION LEVEL FINDING
Action Plan
Overall Responsibility-Chief Nursing officer
Implementation Date- 4.19.23
Cleaning of BD clippers between patient and after patient use according to manufacturer's recommendation
Corrective action #1
Date: 4.19.23
BD hair clippers were cleaned according to manufacturers recommendation

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 4/19/2023
Is a Monitoring Plan Required?: No

Action #2
The findings were reviewed with the Chief Nursing officer, Chief Executive Officer and Chief of Support Services on 4/27/23, who directed the action plan to be developed.
Actual / Potential Outcome: The BD clippers were not cleaned between patients.
CONDITION LEVEL FINDING
Action Plan
Overall Responsibility-Chief Nursing officer
Implementation Date- 4.19.23
Cleaning of BD clippers between patient and after patient use according to manufacturer's recommendation
Corrective action #2
Date: 5.31.23
All nursing staff will be educated on how to properly clean the BD clippers per the manufacturer's recommendations, attestation signed

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: No

Action #3
The findings were reviewed with the Chief Nursing officer , Chief Executive Officer and Chief of Support Services on 4/27/23, who directed the action plan to be developed.
Actual / Potential Outcome: The BD clippers were not cleaned between patients.
CONDITION LEVEL FINDING
Action Plan
Overall Responsibility-Chief Nursing officer
Implementation Date- 4.19.23
Cleaning of BD clippers between patient and after patient use according to manufacturer's recommendation
Corrective action plan #3
Date: 5.31.23
Departmental leaders to ensure daily audits of clippers and clipper base to ensure that it is clean for 1 month. Surveillance will continue monthly thereafter

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: BD Clippers
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance

Who will oversee the monitoring: Chief Nursing Officer
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

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Deficiency #18

Level: Standard–Level
IC-03: Infection Prevention & Control Policies
Requirement: B

The standard was not met as evidenced by the following

REQUIREMENT B

Observed in the ICU (Location #1) – 4/18/23 @ approximately 1120 by A. Martin

Finding: Based on observation of care, the organization could not substantiate that measures are consistently taken to prevent healthcare acquired infections. Specifically, a nurse did not perform hand hygiene when entering the room to scan the patient for medication administration or after leaving the room. Additionally, the nurse then performed hand hygiene and donned gloves prior to preparing IV admixing. However, the nurse then reentered the patient's room, administered the medication, exited the room, and documented the administration on the computer without removing the gloves or performing hand hygiene.
Actual / Potential Outcome: Failure to perform hand hygiene could increase risk of the transmission of infection.
Individual(s) Involved: Staff #2
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #3

Observed in the Med Surg Unit (Location #1) – 4/20/23 @ approximately 1400 by A. Martin

Finding: Based on observation of care, the organization could not substantiate that measures are consistently taken to prevent healthcare acquired infections. Specifically, a nurse did not perform hand hygiene when entering the room to scan the patient prior to medication administration. After scanning the patient, the nurse did complete hand hygiene and placed gloves on while preparing medication and during administration.
Actual / Potential Outcome: Failure to perform hand hygiene could increase risk of the transmission of infection.
Individual(s) Involved: Staff #19
Information Source: Direct observation by surveyor
Finding Confirmed by: None

Action Plan

Action #1

The findings were reviewed with the Chief Nursing officer , Chief Executive Officer and Chief of Support Services on 4/27/23, who directed the action plan to be developed.
REQUIREMENT B

Actual/Potential Outcome: Failure to perform hand hygiene could increase risk of transmission of infection

Action plan

Overall Responsibility-Chief Nursing officer
Implementation Date- 5.8.23
Assuring all employees have performed a hand hygiene competency. Weekly monitoring in all hospital departments for hand hygiene compliance and corrective action follow up for non-compliant employees. Results of hand hygiene audits will be reported to Performance Improvement and Board quality on a monthly basis.

Corrective action #1

Date: 5.31.23
Hand hygiene competency completed by all employees

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 6/16/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Completion of Competency
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Chief Human Resources
What committee in the QAPI program will receive reports on the results: Performance improvement and Board Quality

Action #2

The findings were reviewed with the Chief Nursing officer , Chief Executive Officer and Chief of Support Services on 4/27/23, who directed the action plan to be developed.
REQUIREMENT B
Actual/Potential Outcome: Failure to perform hand hygiene could increase risk of transmission of infection

Action plan
Overall Responsibility-Chief Nursing officer
Implementation Date- 5.8.23
Assuring all employees have performed a hand hygiene competency. Weekly monitoring in all hospital departments for hand hygiene compliance and corrective action follow up for non-compliant employees. Results of hand hygiene audits will be reported to Performance Improvement and Board quality on a monthly basis.

Corrective action #2
Date:5.15.23
Weekly audits in patient care departments of hand hygiene compliance with immediate follow up for non-compliance

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 5/15/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Hand Hygiene Compliance
What is the sample size: 50
What is the threshold of compliance: 90%
How frequently will monitoring occur: Weekly
How long will the monitoring last: ongoing
Who will oversee the monitoring: Director of Quality
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

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Deficiency #19

Level: Standard–Level
IC-07: Disinfection & Sterilization Practices
Requirement: B
The standard was not met as evidenced by the following
REQUIREMENT B
Observed in the ICU (Location #1) – 4/18/23 @ approximately 1142 by A. Martin
Finding: During a tour of the environment, it was noted that instruments are not transported in a manner consistent with the requirements in AAMI ST58. Specifically, instruments are transported from the point of use to the soiled utility room through a public hallway in a biohazard bag that is not puncture resistant. Staff indicated that the instruments are then placed into a container awaiting pick up.

Additionally, it was noted that a glide scope stylet was located in the red biohazard bin and appeared dry. Staff #7 indicated the stylet was not sprayed with enzymatic spray.
Actual / Potential Outcome: Failure to follow AAMI ST58 increases the risk of exposure to biohazard contents.
Individual(s) Involved: ICU staff
Information Source: Discussion with staff #7, AAMI ST58
Finding Confirmed by: Staff #3

Observed in the Emergency Department (Location #1) – 4/19/23 @ approximately 1205 by A. Martin
Finding: During a tour of the environment, it was noted that instruments are not transported in a manner consistent with the requirements in AAMI ST58. Specifically, instruments are transported from the point of use to the soiled utility room through a public hallway in a biohazard bag that is not puncture resistant.

Additionally, it was noted that a glide scope stylet was located in the red biohazard bin and appeared dry. Staff #15 indicated the stylet was not sprayed with enzymatic spray.
Actual / Potential Outcome: Failure to follow AAMI ST58 increases the risk of exposure to biohazard contents and development of biofilm that is unable to be removed during sterilization.
Individual(s) Involved: Registered Nurses
Information Source: Discussion with staff #15, AAMI ST58
Finding Confirmed by: Staff #14

Observed during Survey Activity (Location #1) – 4/18/23 @ approximately 1530 by A. Martin
Finding: Based on information presented at the time of survey, the organization could not substantiate that Bronchoscopy scopes are processed within 7 to 14 days if not used as required by organizational policy. Specifically, Bronchoscope #122749 was last processed on 3/20/23.
Actual / Potential Outcome: Lack of disinfection of scopes could potentially increase the risk of patient infection.
Individual(s) Involved: Sterile processing tech
Information Source: Discussion with staff #10, Direct observation by surveyor, Policy, "Flexible Endoscopes-Reprocessing", last revised January 2022 and in place at the time of survey.
Finding Confirmed by: Staff #8

Action Plan

Action #1
The findings were reviewed with the Chief Nursing Officer on 4.27.23 who directed the action plan to be developed.
Actual / Potential Outcome: Failure to follow AAMI ST58 increase the risk of exposure to biohazard contents and development of biofilm that is unable to be removed during sterilization.
Description: The transport of used surgical supplies will be done in a manner that is safe and supports optimal sterilization of instruments.
Corrective Action 1 –
Policy and Procedure to ensure safe transportation of used surgical supplies from bedside procedures will be written, to include storage location of red biohazard bin before and after use, use of enzymatic spray, and a process that ensures timely delivery of red biohazard bin to Sterile Processing.

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: No

Action #2
All nursing staff in ED, ICU, and nursing supervisors will be educated on the procedure. Attestation of understanding will be obtained from staff

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: No

Action #3
Monitoring transport of used surgical supplies

Title of Person Responsible for Implementing the Action: Chief Nursing officer
Date Action Plan was or will be Implemented: 5/15/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Transport of used Surgical Supplies
What is the sample size: 30 cases
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Manager of Surgical Services
What committee in the QAPI program will receive reports on the results: Performance improvement, Med Exec and Board Quality

Action #4
Bronchoscopes will be clean and in ready condition as needed
Manufacturer does not specifically explain requirements for frequency of sterilization when the bronchoscope is not used. Current policy Flexible Endoscopes-Reprocessing will be updated to reflect the rare use of bronchoscopes, to outline that the bronchoscope must be processed prior to and after each patient use. Approval through Performace improvement, surgery committee, medical executive committee and BOD.

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: No

Deficiency #20

Level: Standard–Level
IC-10: Establishment of an Antibiotic Stewardship Program
Requirement: G

The standard was not met as evidenced by the following

REQUIREMENT G
In 8 of 10 files, the following was noted:
Observed during Medical Staff Credential File Review Session (Location #1) – 4/21/23 @ approximately 1030 by A. Martin
Finding: The credential files of the following practitioners were reviewed. The organization could not substantiate that education was provided on the practical application of antibiotic stewardship. The following files lacked evidence of antibiotic stewardship training:

- A Hospitalist (S.S.) who was last appointed 3/2/23.
- A Surgeon (A.A.) who was last appointed 9/2/21.
- An Anesthesia practitioner (R.R.) who was last appointed 2/2/23.
- An Emergency Room Practitioner (F.W.) who was last appointed 10/6/22.
- A Gynecologist (D.A.) who was last appointed 8/4/22.
- A Pediatrician (C.D.) who was last appointed 1/5/23.
- A Physician Assistant (J.L.) who was last appointed 4/1/23.

Actual / Potential Outcome: Training of practitioners was not documented.
Individual(s) Involved: Medical Staff Credentialling
Information Source: Medical Staff Credential Files
Finding Confirmed by: Staff #1 and Staff #21

Action Plan

Action #1
The findings were reviewed with the Chief Medical Officer on 4.27.23 who directed the following action plan to be developed. There was lack of evidence of antimicrobial stewardship training for multiple providers.

Action Plan
The CMO and the Med Staff office will disseminate a module on antimicrobial stewardship training to the medical staff. Completion of this module will be required and proof that this is done will be included as part of the reappointment application for all physicians.
Action plan completion- 6.13.23

Corrective Action 1
Title: CMO
Date: 6.13.23
Description: The finding was reviewed by the CMO and a module on antimicrobial stewardship was identified. This module will be disseminated to all medical staff.

Corrective Action 2
Title: CMO
Date: May 2, 2023
Description: The reappointment documents will be revised to include antimicrobial stewardship training as a requisite component of reappointment. An attestation that this training was performed will be added to the reappointment application.

Title of Person Responsible for Implementing the Action: Chief Medical Officer
Date Action Plan was or will be Implemented: 6/13/2023
Is a Monitoring Plan Required?: No

Action #2

Corrective Action 2
Title: CMO
Date:
Description: The reappointment documents will be revised to include antimicrobial stewardship training as a requisite component of reappointment. An attestation that this training was performed will be added to the reappointment application.

Title of Person Responsible for Implementing the Action: Chief Medical Officer
Date Action Plan was or will be Implemented: 6/15/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Antimicrobial stewardship completion attestation rates
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly

How long will the monitoring last: ongoing
Who will oversee the monitoring: Chief Medical Officer
What committee in the QAPI program will receive reports on the results: PI/PT, Med exec and Board Quality

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Deficiency #21

Level: Standard–Level
IC-11: Oversight of the Infection Control Program
Requirement: A
The standard was not met as evidenced by the following
REQUIREMENT A
Observed during Document Review (Location #1) – 4/18/23 @ approximately 0955 by A. Martin
Finding: Based on information presented at the time of survey, the organization could not substantiate that it has designated in writing the individual responsible for direction and oversight of the infection control program as required by this standard.
Actual / Potential Outcome: The organization has not designated an infection control leader in writing.
Individual(s) Involved: Administration
Information Source: Document review.
Finding Confirmed by: Staff #1

Action Plan

Action #1
The findings were reviewed with the Chief Medical Officer who directed the following action plan to be developed.
Actual/Potential outcome: The organization has not designated an infection control leader in writing

Action Plan

Overall responsibility- Chief Medical Officer
Date implemented 5.24.23
The medical director of Infection Control was identified and credentialed and approved by the board as a physician, however had not been approved by the board as the designated infection control leader. This physician leads our Infectious Disease Consultation Service and leads the Antimicrobial Stewardship Program and will be presented as such on 5.18.23 to the Medical Executive committee and 5.24.23 Board Quality Committees.

Corrective Action 1

Title: Presentation of Infection Control Medical Director as the designated infection control leader and leader of the antimicrobial stewardship program to Medical Executive committee and Board Quality
Date: May 24, 2023
Description: The finding was reviewed by CMO

Title of Person Responsible for Implementing the Action: Chief Medical Officer
Date Action Plan was or will be Implemented: 5/24/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Confirmation of Medical Director of Infection Control
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Annually
How long will the monitoring last: ongoing
Who will oversee the monitoring: Chief Medical Officer
What committee in the QAPI program will receive reports on the results: Medical Executive and Board Quality Committee

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Deficiency #22

Level: Standard–Level
PR-02: Informing Patients of Their Rights
Requirement: D
The standard was not met as evidenced by the following
REQUIREMENT D
Observed during Document Review (Location #1) – 4/19/23 @ approximately 0910 by A. Martin
Finding: Based on information presented at the time of survey, the organization could not substantiate that the Important Message from Medicare is provided in a timely manner. An audit was performed that showed 3 of 10 patients did not receive the IMM within two days of admission.
Actual / Potential Outcome: Lack of presenting the IMM could result in patients not being aware of their right to appeal a premature discharge.
Individual(s) Involved: DC planner

Information Source: IMM audit form
Finding Confirmed by: Staff #1

Action Plan

Action #1
The findings were reviewed with the Chief Ancillary Officer on 4.27.23 who directed the action plan to be developed.
Actual/potential outcome: Lack of presenting the Important Message from Medicare could result in patients not being aware of their rights to appeal a premature discharge.

Corrective Action Plan:

Patient Access Manager
6.3.23
A new process will be implemented to ensure that the important Message for Medicare is provided to patients within 2 days of admission. This process will be implemented within 30 days or June 3rd, 2023. In addition, Patient Access will implement a performance improvement plan to monitor this process.
The Patient Access Manager will monitor this weekly, and outcomes will be reported to the Quality Committee.

Title of Person Responsible for Implementing the Action: Patient Access Manager
Date Action Plan was or will be Implemented: 6/3/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: IMM letter completion
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Weekly
How long will the monitoring last: 6 months of Continuous compliance
Who will oversee the monitoring: Patient access manager
What committee in the QAPI program will receive reports on the results: Performance Improvement, Board Quality

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Deficiency #23

Level: Standard–Level
PR-03: Notification of Hospitalization
Requirement: A

The standard was not met as evidenced by the following

REQUIREMENT A
In 2 of 27 records, the following was noted
Observed during Medical Record Review (Location #1) – 4/20/23 @ approximately 1130 by A. Martin
Finding: The medical record of Patient #16 was reviewed. It was noted that the medical record lacked evidence that the patient was asked if she would like to have a family member notified of her admission.
Actual / Potential Outcome: Failure to ask patients if they would like their own family notified could impact family involvement in patient care.
Individual(s) Involved: Registration
Information Source: Electronic Health Record
Finding Confirmed by: Staff #1

Observed during Medical Record Review (Location #1) – 4/20/23 @ approximately 1145 by A. Martin
Finding: The medical record of Patient #17 was reviewed. It was noted that the medical record lacked evidence that the patient was asked if she would like to have a family member notified of her admission.
Actual / Potential Outcome: Failure to ask patients if they would like their own family notified could impact family involvement in patient care.
Individual(s) Involved: Registration.
Information Source: Electronic Health Record
Finding Confirmed by: Staff #1

Action Plan

Action #1
The findings were reviewed the Chief Ancillary Officer on 4.27.23 who directed the action plan to be developed.
Actual/Potential Outcome: Failure to ask patients if they would like their own family notified could impact family involvement in patient care.

Action Plan:

Patient Access Manager
6.3.23

A new process will be implemented to ensure that staff are asking patients if they would like their family members notified on admission. This will be documented in the electronic health record. This process will be implemented within 30 days or June 3rd, 2023. In addition, Patient Access will implement a performance improvement plan to monitor this process.
The Patient Access Manager will monitor this weekly, and outcomes will be reported to the Quality Committee.

Title of Person Responsible for Implementing the Action: Patient Access Manager
Date Action Plan was or will be Implemented: 6/3/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Notification of Hospitalization to family
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Weekly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Patient Access Manager
What committee in the QAPI program will receive reports on the results: Performance Improvement, Board Quality

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Deficiency #24

Level: Standard–Level
PR-03: Notification of Hospitalization
Requirement: B

The standard was not met as evidenced by the following

REQUIREMENT B
In 2 of 27 records, the following was noted
Observed during Medical Record Review (Location #1) – 4/20/23 @ approximately 1130 by A. Martin
Finding: The medical record of Patient #16 was reviewed. It was noted that the medical record lacked evidence that the patient was asked if she would like to have her own physician notified of her admission.
Actual / Potential Outcome: Failure to ask patients if they would like their own physician notified could impact continuity of care.
Individual(s) Involved: Registration
Information Source: Electronic Health Record
Finding Confirmed by: Staff #1

Observed during Medical Record Review (Location #1) – 4/20/23 @ approximately 1145 by A. Martin
Finding: The medical record of Patient #17 was reviewed. It was noted that the medical record lacked evidence that the patient was asked if she would like to have her own physician notified of her admission.
Actual / Potential Outcome: Failure to ask patients if they would like their own physician notified could impact continuity of care.
Individual(s) Involved: Registration
Information Source: Electronic Health Record
Finding Confirmed by: Staff #1

Action Plan

Action #1
The findings were reviewed with the Chief Ancillary Officer on 4.27.23 who directed the action plan to be developed.
Actual/Potential Outcome: Failure to ask patients if they would like their own physician notified could impact continuity of care.

Corrective Action Plan:

Patient Access Manager
6.3.23
A new process will be implemented to ensure that staff are asking patients if they would like their provider notified on admission. This will be documented in the electronic health record. This process will be implemented within 30 days or June 3rd, 2023. In addition, Patient Access will implement a performance improvement plan to monitor this process.
The Patient Access Manager will monitor this daily, and outcomes will be reported to the Quality Committee.

Title of Person Responsible for Implementing the Action: Patient Access Manager
Date Action Plan was or will be Implemented: 6/3/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Notification of Hospitalization to providers
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Weekly

How long will the monitoring last: 6 months of Continuous Compliance
Who will oversee the monitoring: Patient Access Manager
What committee in the QAPI program will receive reports on the results: Performance Improvement, Board Quality

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Deficiency #25

Level: Standard–Level
MM-08: Security of Medications
Requirement: C

The standard was not met as evidenced by the following

REQUIREMENT C

Observed in the Med Surg Unit (Location #1) – 4/19/23 @ approximately 1115 by A. Martin

Finding: Based on discussions with staff, the organization could not substantiate that controlled substances are wasted into approved pharmaceutical waste receptacles. Staff are disposing unused controlled substances into a purple bin with an open lid. This would not be consistent with DEA regulations at §1300.05 which require controlled medication waste to be non-retrievable. In discussion with staff the container is similar to a sharps container and contents could be retrieved.
Actual / Potential Outcome: Failure to dispose of controlled substances in a secure could lead to theft and misuse of the medications.
Individual(s) Involved: None
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #6 and Staff #25

Action Plan

Action #1
The findings were reviewed with the Chief Executive Officer and Director of Pharmacy on 4/27/23 who directed the action plan to be developed._
The use of "Rx Destroyer" drug disposal system will be implemented.
Actual/potential outcome- Failure to dispose of controlled substances in a secure manner could lead to theft and misuse of medication
Place order for 6 Rx Destroyer kits

Title of Person Responsible for Implementing the Action: Director of Pharmacy
Date Action Plan was or will be Implemented: 5/1/2023
Is a Monitoring Plan Required?: No

Action #2
The lock boxes to secure Rx Destroyer will be installed in Medsurg (3E & 3C), ICU, SCU, OR, & ER

Title of Person Responsible for Implementing the Action: Director of Pharmacy
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: No

Action #3
A policy/procedure will be created and approved by the BOD describing the proper use and management of the Rx Destroyer and education provided to staff

Title of Person Responsible for Implementing the Action: Director of Pharmacy
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: No

Deficiency #26

Level: Standard–Level
MM-11: Emergency Medications
Requirement: B

The standard was not met as evidenced by the following

REQUIREMENT B

Observed in the Emergency Department (Location #1) – 4/19/23 @ approximately 1115 by A. Martin

Finding: During a tour of the environment, it was noted that the organization uses the Broselow system for pediatric resuscitation - including the selection and dosing of emergency medications. This system calls for the availability of 10% Dextrose for infants up to 5kg in weight. This concentration was not available in the resuscitation cart. It is noted that 10% Dextrose is commercially available.
Actual / Potential Outcome: Not having emergency medications available in their most ready-to-administer form could result in treatment delay.

Individual(s) Involved: None
Information Source: Direct observation by surveyor.
Finding Confirmed by: Staff #14

Action Plan

Action #1
The findings were reviewed with the Chief Executive Officer & Director of Pharmacy on 4/2723, who directed the action plan to be developed.
Actual/Potential outcome: Not having emergency medications available in their most ready to administer form could result in treatment delay

Corrective Action 1

Title: Update Broselow Contents list in policy "Code Blue and Broselow Emergency Resuscitation Cart Maintenance"
Description: The contents list that is part of the above policy must be updated to include Dextrose 10% injection and approved by pharmacy & therapeutics committee, med exec and board quality

Title of Person Responsible for Implementing the Action: Director of Pharmacy
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: No

Action #2
Pharmacy staff to determine best location within the Broselow Carts for Dextrose 10% to be stored.

Title of Person Responsible for Implementing the Action: Director of Pharmacy
Date Action Plan was or will be Implemented: 5/8/2023
Is a Monitoring Plan Required?: No

Action #3
The broselow carts will have the Dextrose 10% physically added to its stock.

Title of Person Responsible for Implementing the Action: Director of Pharmacy
Date Action Plan was or will be Implemented: 6/15/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: presence of Dextrose 10% in the Broselow carts
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 Months of continuous compliance
Who will oversee the monitoring: Director of Pharmacy
What committee in the QAPI program will receive reports on the results: Medical Staff: Pharmacy & Therapeutics, Med Exec and Board Quality

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Deficiency #27

Level: Standard–Level
MM-21: Use of Protocols
Requirement: A

The standard was not met as evidenced by the following

REQUIREMENT A
Observed during Survey Activity (Location #1) – 4/20/23 @ approximately 1200 by A. Martin
Finding: Based on information presented at the time of survey, the organization could not substantiate that protocols used for the administration of contrast meet accepted standards of care. Specifically, staff stated that a protocol is used and approved by the radiologist that guides staff on the type of contrast and dose to be administered for an exam. However, the protocol does not provide clear or further direction for specific dose or which contrast to use for the various imaging exams or dosage for staff to administer.
Actual / Potential Outcome: Insufficient guidance for medication administration could put the patient at risk for incorrect dosing or an inadequate exam.
Individual(s) Involved: Radiology
Information Source: Policy/protocol: "Intravenous Contrast Administration, CT and X-ray", (7630-159) last reviewed February 2023 and in place at the time of survey.
Finding Confirmed by: Staff #9 and #22

Action Plan

Action #1
The findings were reviewed with the CMO and the Chief ancillary officer on 4.27.23. The Chief Ancillary Officer, Director of Pharmacy and Director of Diagnostic Services reviewed the findings in an in-person meeting 5/2/2023.
Actual potential outcome- Insufficient guidance for medication administration could put the patient at risk for incorrect dosing or an inadequate exam.
Protocol sheets will be updated to include medication type and dose for ordered examination.

Title of Person Responsible for Implementing the Action: Director of Diagnostic Services
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: No

Action #2
Updated Protocol sheets will be approved by appropriate committees. Protocol sheets will be sent to the Pharmacy and Therapeutics Committee, Medicine Committee, Surgery Committee and Medical Executive Committee for approval and then to Board Quality Committee for review. Newly updated protocol sheets will be implemented when BOD approval is granted.

Title of Person Responsible for Implementing the Action: Director of Diagnostic Services
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Protocol usage
What is the sample size: 30 or 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Director of Diagnostic Services
What committee in the QAPI program will receive reports on the results: Med Staff PI/Pharmacy & Therapeutics & Board Quality Committee

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Deficiency #28

Level: Standard–Level
MM-21: Use of Protocols
Requirement: C

The standard was not met as evidenced by the following

REQUIREMENT C

Observed during Survey Activity (Location #1) – 4/20/23 @ approximately 1200 by A. Martin
Finding: Based on information present at the time of survey, the organization could not substantiate that the medical staff, pharmacy, and respiratory had approved the protocol used to guide the administration of albuterol during a complete pulmonary function test in the pulmonary function testing department.
Actual / Potential Outcome: The policy/protocol was not approved by pharmacy.
Individual(s) Involved: Pharmacy
Information Source: Discussions with staff #, Policy/protocol: "Pulmonary Function Testing, (7721-62) last reviewed October 2014 and in place at the time of survey.
Finding Confirmed by: Staff #9 and Staff #25

Observed during Survey Activity (Location #1) – 4/20/23 @ approximately 1200 by A. Martin
Finding: Based on information presented at the time of survey, the organization could not substantiate that pharmacy had approved the protocols used to guide the administration of CT and MRI contrast in the imaging department.
Actual / Potential Outcome: The policy/protocol was not approved by pharmacy.
Individual(s) Involved: Pharmacy
Information Source: Discussions with staff #9, Policy/protocol: "Intravenous Contrast Administration, CT and X-ray", (7630-159) last reviewed February 2023 and in place at the time of survey.
Finding Confirmed by: Staff #25

Action Plan

Action #1
The findings were reviewed with the CMO and the Chief ancillary officer on 4.27.23. The Chief Ancillary Officer, Director of Pharmacy and Director of Diagnostic Services reviewed the findings in an in-person meeting 5/2/2023. Actual potential outcome- The policy/protocol was not approved by pharmacy

Protocols for pulmonary function tests and CT/MRI will be reviewed, updated and submitted to the Director of Pharmacy for approval and then Pharmacy and Therapeutics Committee, and Medical Executive Committee for approval and then to Board Quality Committee for review and BOD for approval 6.1.23

Title of Person Responsible for Implementing the Action: Director of Diagnostic Services
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: No

Deficiency #29

Level: Standard–Level
MM-21: Use of Protocols
Requirement: E

The standard was not met as evidenced by the following

REQUIREMENT E
In 3 of 27 records, the following was noted
Observed during Medical Record Review (Location #1) – 4/19/23 @ approximately 1445 by A. Martin
Finding: The medical record of Patient #2 was reviewed. It was noted that Albuterol w/MDI 2 puffs were administered without a practitioner order. Based on discussion with staff #12, the amount and type of albuterol was administered per protocol. However, the medical record lacked evidence that the protocol used for Pulmonary Function Testing (PFT) was made part of the medical record.
Actual / Potential Outcome: Incomplete information in the medical record can lead to lack of clarity in communication and treatment decisions compromising patient safety.
Individual(s) Involved: PFT Staff
Information Source: Discussion with Staff #, Protocol: "Pulmonary Function Testing", (7721-62), last approved October 2014 and in place at the time of survey.
Finding Confirmed by: Staff #1

Observed during Medical Record Review (Location #1) – 4/19/23 @ approximately 1500 by A. Martin
Finding: The medical record of Patient #3 was reviewed. It was noted that there was an order for CT abdomen and pelvis with contrast. Staff indicated the amount and type of contrast was administered per protocol. The medical record lacked evidence that the protocol was made part of the medical record.
Actual / Potential Outcome: Incomplete information in the medical record can lead to lack of clarity in communication and treatment decisions compromising patient safety.
Individual(s) Involved: Radiology staff
Information Source: Medical record
Finding Confirmed by: Staff #9

Observed during Medical Record Review (Location #1) – 4/19/23 @ approximately 1515 by A. Martin
Finding: The medical record of Patient #4 was reviewed. It was noted that there was an order for an MRI of the brain with and without contrast. The medical record lacked evidence that the contrast was administered per protocol. Staff indicated that they follow a weight-based protocol to guide the amount of contrast administered.

Additionally, the protocol was not made part of the medical record.
Actual / Potential Outcome: Incomplete information in the medical record can lead to lack of clarity in communication and treatment decisions compromising patient safety.
Individual(s) Involved: Radiology staff
Information Source: Medical record
Finding Confirmed by: Staff #9

Action Plan

Action #1
The findings were reviewed with the CMO and the Chief ancillary officer on 4.27.23. The Chief Ancillary Officer, Director of Pharmacy and Director of Diagnostic Services reviewed the findings in an in-person meeting 5/2/2023.
Actual potential outcome: Incomplete information in the medical record can lead to lack of clarity in communication and treatment decisions compromising patient safety.

Action Plan

Director of Diagnostic Services
5/2/2023
PFT exams are done on an outpatient basis. At the time of scheduling an albuterol administration order will be obtained. Orders are entered into the EMR.
Protocol sheets approved and signed by the radiologist/LIP are scanned into the EMR.
Protocol sheets will be updated to include the type and dose of medication to be given for each exam requiring medication.

Corrective Action 1
The pulmonary function test scheduling process will be changed so that an order for albuterol is obtained along with the exam order. The orders for the PFT exam and albuterol medication will be entered into the patients EMR record.
Protocol sheets for CT/MRI will be updated to include medication type and dose. Medication protocol sheets/medication orders will be entered into the EMR.

Title of Person Responsible for Implementing the Action: Director of Diagnostic Services
Date Action Plan was or will be Implemented: 6/2/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Appropriate protocol completion
What is the sample size: 30 or 100%
What is the threshold of compliance: 90 %
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Director of Diagnostic Services
What committee in the QAPI program will receive reports on the results: PI/Pharmacy & Therapeutics & Board Quality Committee

Action #2
Corrective Action 2
Updated Protocol sheets will be updated and submitted to the Director of Pharmacy for approval and then Pharmacy and Therapeutics Committee, and Medical Executive Committee for approval and then to Board Quality Committee for review and BOD for approval on 6.1.23

Title of Person Responsible for Implementing the Action: Director of Pharmacy
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: No

Deficiency #30
Level: Standard–Level
MM-22: Medication Orders
Requirement: H
The standard was not met as evidenced by the following
REQUIREMENT H
In 1 of 27 records, the following was noted
Observed during Medical Record Review (Location #1) – 4/20/23 @ approximately 1545 by A. Martin
Finding: The medical record of Patient #21 was reviewed. It was noted that Dilaudid and Oxycodone were both ordered PRN for pain. The orders were not clarified to provide sufficient direction to personnel in determining which PRN medication to administer.
Actual / Potential Outcome: The orders result in duplicate therapy and were not clarified.
Individual(s) Involved: Registered Nurse and ordering practitioner
Information Source: Medication administration record, Policy; "Ordering and Prescribing", (MM8610-133) last reviewed April 2023 and in place at the time of survey.
Finding Confirmed by: Staff #1

Action Plan
Action #1
The findings were reviewed with the Chief Executive Officer on 4/27/23 who directed the action plan to be developed.
Reported need for specific indications and PRN instructions to senior leadership and Providence Community Technologies; an expedited optimization request was filed to upgrade electronic health record
Clinical Optimization #2319247: CMS Citation - Pain Medication Orders
DOQ is monitoring progress

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 5/2/2023
Is a Monitoring Plan Required?: No

Action #2
Date: 5/21/2023
Description: Completion of EHR optimization
Clinical Optimization #2319247: CMS Citation - Pain Medication Orders

Vendor to complete update to Epic CT EHR

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 5/21/2023
Is a Monitoring Plan Required?: No

Action #3
Description: Medical staff will be educated at the Pharmacy & Therapeutics committee meeting 5/25/2023 as to the importance of using order sets when placing orders for pain medications to ensure that proper PRN parameters and instructions are available and used. An email communication from the Medical Staff Coordinator will also be sent to reach all providers who have medication ordering privileges after the P&T Meeting.

Title of Person Responsible for Implementing the Action: Director of Pharmacy
Date Action Plan was or will be Implemented: 5/25/2023
Is a Monitoring Plan Required?: No

Action #4
Description: Medical staff will be educated at the Pharmacy & Therapeutics committee meeting 5/25/2023 as to the importance of utilizing accurate and complete PRN instructions and parameters when placing one-off orders for pain medications. An email communication from the Medical Staff Coordinator will also be sent to reach all providers who have medication ordering privileges after the P&T Meeting.

Title of Person Responsible for Implementing the Action: Director of Pharmacy
Date Action Plan was or will be Implemented: 5/25/2023
Is a Monitoring Plan Required?: No

Action #5
Pharmacy and nursing staff will be educated as to the importance of screening orders for accurate and complete PRN instructions and parameters for pain medications. An attestation of understanding will be signed by staff.

Title of Person Responsible for Implementing the Action: Director of Pharmacy
Date Action Plan was or will be Implemented: 5/25/2023
Is a Monitoring Plan Required?: No

Action #6
A request for a patient list to be created in Epic will be placed that will allow the pharmacist to quickly identify patients on more than one pain medication so that they can be screened for proper PRN instructions and parameters.
work order #RITM2492328

Title of Person Responsible for Implementing the Action: Director of Pharmacy
Date Action Plan was or will be Implemented: 6/15/2023
Is a Monitoring Plan Required?: No

Action #7
using the list of patients with >1 pain medication to monitor for complete PRN instructions and parameters

Title of Person Responsible for Implementing the Action: Director of Pharmacy
Date Action Plan was or will be Implemented: 6/21/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: PRN Pain Parameter instructions
What is the sample size: 30 or 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Director of Pharmacy
What committee in the QAPI program will receive reports on the results: Pharmacy & Therapeutics, Med Exec and Board Quality Committee

Deficiency #31

Level: Condition–Level
MM-24: Preparation of Medications
Requirement: C

The standard was not met as evidenced by the following

REQUIREMENT C

Observed in the Medical Surgical Unit (Location #1) – 4/18/23 @ approximately 1105 by A. Martin
Finding: During a tour of the environment, it was noted that there was a significant amount of white powdered residue and dust / grime on a Silent Knight pill crusher in the medication prep area. The device is used on multiple patients.
Actual / Potential Outcome: Ineffective cleaning of pill crusher could lead to medication contamination and potentially cause an adverse drug reaction.
Individual(s) Involved: Nursing Staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #2

Observed in the ICU (Location #1) – 4/18/23 @ approximately 1130 by A. Martin
Finding: During a tour of the environment, it was noted that there was a significant amount of white residue and dust/grime on a Silent Knight pill crusher in the medication area. The device is used on multiple patients.
Actual / Potential Outcome: The pill crusher was not cleaned effectively.
Individual(s) Involved: Nursing staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #3

THESE FINDINGS AGGREGATE TO A CONDITION LEVEL DEFICIENCY

Action Plan

Action #1
The findings were reviewed with the Chief Nursing Officer on 4.27.23, who directed the action plan to be developed. Ineffective cleaning of pill crusher could lead to medication contamination and potentially cause an adverse drug reaction.
Pill crushers will be cleaned prior to and after each use to ensure no potential contamination.
Pill crushers inspected and cleaned

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 4/24/2023
Is a Monitoring Plan Required?: No

Action #2
Discussion during staff meeting on 4/28/23 of finding as well as placed in ICU and MS Huddle binder.
Title of Person Responsible for Implementing the Action: Director of Nursing
Date Action Plan was or will be Implemented: 4/28/2023
Is a Monitoring Plan Required?: No

Action #3
All staff educated on need to clean pill crusher. Attestion of understanding obtained
Title of Person Responsible for Implementing the Action: Director of Nursing
Date Action Plan was or will be Implemented: 5/19/2023
Is a Monitoring Plan Required?: No

Action #4
Visual inspection of pill crushers to ensure cleanliness on both units by unit leadership
Title of Person Responsible for Implementing the Action: Director of Nursing
Date Action Plan was or will be Implemented: 5/7/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Inspection of pill crusher in ICU & MedSurg
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Chief Nursing Officer
What committee in the QAPI program will receive reports on the results: Performance improvement, Med Exec and Board Quality Committee

Deficiency #32

Level: Standard–Level
MM-26: Labeling of Medications
Requirement: B

The standard was not met as evidenced by the following

REQUIREMENT B
Observed in the OR (Location #1) – 4/18/23 @ approximately 1400 by A. Martin
Finding: During a tour of the environment, it was noted that four (4) vials of Lidocaine were opened but not dated with a beyond-use-date of 28 days in the anesthesia cart in OR#2. Staff #8 stated the vial should have been tossed and are only used for single patient use.
Actual / Potential Outcome: Storing medications outside of the recommendation beyond use date could result in comprised drug efficacy and/or contamination.
Individual(s) Involved: Anesthesia
Information Source: Direct observation by surveyor.
Finding Confirmed by: Staff #6 and Staff #8

Action Plan

Action #1
The findings were reviewed with the Chief Executive Officer and Director of Pharmacy on 4/27/23, who directed the action plan to be developed.
Surgical staff advised to dispose of any open vials after completion of each case. Vials will be disposed into the appropriate pharmaceutical waste receptacle.

Title of Person Responsible for Implementing the Action: Director of Pharmacy
Date Action Plan was or will be Implemented: 5/1/2023
Is a Monitoring Plan Required?: No

Action #2
Monitor the OR carts daily for presence of unlabeled lidocaine vials, report monthly

Title of Person Responsible for Implementing the Action: Director of Pharmacy
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Presence of unlabeled lidocaine multidose vials daily
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Manager of Surgical Services
What committee in the QAPI program will receive reports on the results: Pharmacy & Therapeutics, Med Exec and Board Quality

Deficiency #33

Level: Standard–Level
MR-05: Minimum Content of the Medical Record
Requirement: G

The standard was not met as evidenced by the following

REQUIREMENT G
In 1 of 27 records, the following was noted
Observed during Medical Record Review (Location #1) – 4/20/23 @ approximately 1015 by A. Martin
Finding: The medical record of Patient #12 was reviewed. It was noted that the medical record lacked evidence that the patient was monitored after receiving Tenecteplase per organizational policy. Specifically, the patient received Tenecteplase on 4/10/23 at 1038. Organizational policy indicates vital signs should be monitored every 15 minutes for two (2) hours post bolus, then every 30 minutes for six (6) hours, then every hour for 24 hours. The medical record lacked documentation of vital signs on 4/10/23 at 1115, 1530, 1700, 1730, 1800, and 1830, and on 4/11/23 at 0800 and 0900.
Actual / Potential Outcome: Failure to monitor the patient could result in a delay in the identification of complications.
Individual(s) Involved:
Information Source: Electronic Medical Record, Policy: “Code Stroke Practice Guidelines”, (NS8610-122), last revised February 2022

and in place at the time of survey
Finding Confirmed by: Staff #1 and #14

Action Plan

Action #1
Reeducation of ED, Critical Care and Nurse Supervisor staff on proper monitoring post TNK administration per hospital policy. Attestation of understanding obtained.

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: No

Action #2
Retrospective review of charts-- all patients that receive TNK

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 6/15/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Vital Signs appropriate cadence for TNK patients
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Chief Nursing Officer
What committee in the QAPI program will receive reports on the results: Performance improvement, Med Exec and Board Quality

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Deficiency #34

Level: Standard–Level
RS-07: Initial Order for Restraint / Seclusion
Requirement: B

The standard was not met as evidenced by the following

REQUIREMENT B
In 1 o 27 records, the following was noted
Observed during Medical Record Review (Location #1) – 4/20/23 @ approximately 1030 by A. Martin
Finding: The medical record of Patient #13 was reviewed. It was noted that an order for restraints was entered 90 minutes after the initiation of restraints. Specifically, the patient was placed into non-violent/non-self-destructive restraints on 4/20/23 at 0100, and the order was not entered into the medical record until 4/20/23 at 0230.
Actual / Potential Outcome: The restraint order was not received in a timely manner.
Individual(s) Involved: Nursing staff
Information Source: Physician orders, restraint documentation
Finding Confirmed by: Staff #2

Action Plan

Action #1
The findings were reviewed with the Chief Nursing Officer on 4.27.23 , who directed the action plan to be developed.
Actual / Potential Outcome: Restraint orders not received in a timely manner.
Action Plan
Overall responsibility: Chief Nursing Officer, Director of Patient Care Services, Director of Emergency Services
Completion Date: 6/16/2023
Description: There will be timely orders obtained upon the application of restraints.
Corrective Action 1 –
Date: 6.16.23
Reeducation of ED and inpatient nursing staff on the need to obtain MD orders upon the initiation of restraints, to be completed and attestation signed.

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 6/16/2023
Is a Monitoring Plan Required?: No

Action #2

The findings were reviewed with the Chief Nursing Officer on 4.27.23 , who directed the action plan to be developed.
Actual / Potential Outcome: Restraint orders not received in a timely manner.
Action Plan
Overall responsibility: Chief Nursing Officer, Director of Patient Care Services, Director of Emergency Services
Completion Date: 6/16/2023
Description: There will be timely orders obtained upon the application of restraints.
Corrective Action 2 –
Date: 5.7.23
Chart audit of every patient in restraints

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 5/8/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Presence of timely MD order per policy
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Chief Nursing Officer
What committee in the QAPI program will receive reports on the results: Performance Improvement, Medical Executive Committee and Board Quality

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Deficiency #35

Level: Standard–Level
RS-12: Training of Practitioners Who Order Restraint / Seclusion
Requirement:
The standard was not met as evidenced by the following
RS-12
In 6 of 10 files, the following was noted
Observed during Medical Staff Credential File Review Session (Location #1) – 4/21/23 @ approximately 1015 by A. Martin
Finding: The credential files of the following practitioners were reviewed. The organization could not substantiate that education was provided on the organization's policy regarding the use of restraint or seclusion. The following practitioners lacked evidence of education.

- A Hospitalist (S.S.) who was last appointed 3/2/23.
- A Surgeon (A.A.) who was last appointed 9/2/21.
- An Anesthesia practitioner (R.R.) who was last appointed 2/2/23.
- An Emergency Room Practitioner (F.W.) who was last appointed 10/6/22.
- A Pediatrician (C.D.) who was last appointed 1/5/23.
- A Physician Assistant (J.L.) who was last appointed 4/1/23.

Actual / Potential Outcome: Lack of training could result in the providers inability to safely manage a patient in restraints.
Individual(s) Involved: None
Information Source: Medical Staff Credential Files
Finding Confirmed by: Staff #1 and #21

Action Plan

Action #1
The findings were reviewed with the Chief Medical Officer on 4/27/23 who directed the following action plan to be developed. There was lack of evidence of restraints training for multiple providers.
Action Plan
The Chief Medical Officer and the Med Staff office will disseminate the Sonoma Valley Hospital policy on restraints. Attestation that all physicians have read this policy will be required during now and at reappointment application.
Corrective Action 1
Title: CMO
Date: May 15, 2023
Description: The finding was reviewed by the CMO and the restraint policy was identified and will be disseminated to all medical staff for attestation.

Title of Person Responsible for Implementing the Action: Chief Medical Officer
Date Action Plan was or will be Implemented: 5/15/2023
Is a Monitoring Plan Required?: No

Action #2
The findings were reviewed with the Chief Medical Officer on 4/27/23 who directed the following action plan to be developed. There was lack of evidence of restraints training for multiple providers.

Action Plan

The CMO and the Med Staff office will disseminate the Sonoma Valley Hospital policy on restraints. Attestation that all physicians have read this policy will be required during now and at reappointment application.

Corrective Action 2

Title: CMO
Date: May 15, 2023
Description: The reappointment documents will be revised to include review of restraint policy as a requisite component of reappointment. An attestation that this policy was reviewed will be added to the reappointment application.

Title of Person Responsible for Implementing the Action: Chief Medical Officer
Date Action Plan was or will be Implemented: 5/15/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Restraint policy review attestation rates
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: Ongoing
Who will oversee the monitoring: Chief Medical Officer
What committee in the QAPI program will receive reports on the results: Performance Improvement, Medical Executive Committee Board Quality

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Deficiency #36

Level: Standard–Level
QS-07: Accuracy in Patient Identification
Requirement: A

The standard was not met as evidenced by the following

REQUIREMENT A
Observed in the ICU (Location #1) – 4/18/23 @ approximately 1120 by A. Martin
Finding: Based on observation of care, the organization could not substantiate that staff appropriately identified the patient prior to the administration of medications. Specifically, a nurse was observed entering the patient room to administer medication without using two distinct identifiers prior to the administration of Protonix.
Actual / Potential Outcome: The nurse did not use two (2) identifiers prior to the administration of medication.
Individual(s) Involved: Staff #4
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #3

Action Plan

Action #1
The findings were reviewed with the Chief Nursing Officer, who directed the action plan to be developed.

Actual / Potential Outcome: The nurse did not use two identifiers prior to administration of medication. Patient harm may result if given the wrong medication.

Action Plan

Overall responsibility: Chief Nursing Officer, Director of Patient Care Services, Director of Emergency Services, Surgical Services Manager
Completion Date: 6/16/2023
Description: A patient will be asked to verify their name and date of birth, in addition to bracelet barcode scanning.

Corrective Action 1

Date: 6.16.23
Reeducation of respiratory therapists, nursing staff in ED, surgical areas, and the inpatient team to include the need to use two patient identifiers, including bracelet barcode scanning, attestation form will be signed

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 6/16/2023
Is a Monitoring Plan Required?: No

Action #2
The findings were reviewed with the Chief Nursing Officer, who directed the action plan to be developed.
Actual / Potential Outcome: The nurse did not use two identifiers prior to administration of medication. Patient harm may result if given the wrong medication.
Action Plan
Overall responsibility: Chief Nursing Officer, Director of Patient Care Services, Director of Emergency Services, Surgical Services Manager
Completion Date: 6/16/2023
Description: A patient will be asked to verify their name and date of birth, in addition to bracelet barcode scanning.
Corrective Action 2 –
Date: 6.16.23 Observations of patient identification practice in all departments

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 6/16/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Patient identification procces
What is the sample size: 30
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Chief Nursing Officer
What committee in the QAPI program will receive reports on the results: Performance Improvement, Medical Executive Committee and Board Quality

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Deficiency #37
Level: Condition–Level
QS-10: Protecting Patients from Self-Harm
Requirement: D
The standard was not met as evidenced by the following
REQUIREMENT D
In 1 of 27 records, the following was noted
Observed during Medical Record Review (Location #1) – 4/20/23 @ approximately 1200 by A. Martin
Finding: The medical record of Patient #18 was reviewed. It was noted that the patient was at risk of self-harm and not placed on 1:1 continuous observation in the emergency department. Specifically, it was documented that the patient had suicidal ideation with a plan and there was no documentation to support the patient was placed on 1:1 continuous observation.
Actual / Potential Outcome: Lack of a 1:1 continuous observation could potentially be detrimental to the patient's right to receive care in a safe setting.
Individual(s) Involved: Staff caring for the patient
Information Source: Electronic Health Record.
Finding Confirmed by: Staff #1 and #14
THIS IS A CONDITION LEVEL DEFICIENCY

Action Plan
Action #1
The findings were reviewed with the Chief Nursing Officer on 4.27.23 who directed the action plan to be developed.
Actual / Potential Outcome: Lack of a 1:1 continuous observation could potentially be detrimental to the patient's right to receive care in a safe setting.
Action Plan
Overall responsibility: Chief Nursing Officer; Director of Emergency Services
Completion Date: 5.31.23
Description: MD orders and nursing documentation will accurately reflect 1:1 continuous observation of patients who are at risk of self-harm.
Corrective Action 1–
Date: 5.31.23
Chief Nursing Officer

All ED MDs will be educated to place an order for 1:1 continuous observation for patients at risk, attestation form will be signed.

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: No

Action #2
The findings were reviewed with the Chief Nursing Officer on 4.27.23 who directed the action plan to be developed.
Actual / Potential Outcome: Lack of a 1:1 continuous observation could potentially be detrimental to the patient's right to receive care in a safe setting.
Action Plan
Overall responsibility: Chief Nursing Officer; Director of Emergency Services
Completion Date: 5.31.23
Description: MD orders and nursing documentation will accurately reflect 1:1 continuous observation of patients who are at risk of self-harm.
Corrective Action 2 –
Date: 5.31.23
All nursing staff in ED, and nursing supervisors will be educated on the EPIC flowsheet documentation for observation of patients at risk of self-harm
Attestation form will be signed.

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: No

Action #3
The findings were reviewed with the Chief Nursing Officer on 4.27.23 who directed the action plan to be developed.
Actual / Potential Outcome: Lack of a 1:1 continuous observation could potentially be detrimental to the patient's right to receive care in a safe setting.
Action Plan
Overall responsibility: Chief Nursing Officer; Director of Emergency Services
Completion Date: 5.31.23
Description: MD orders and nursing documentation will accurately reflect 1:1 continuous observation of patients who are at risk of self-harm.
Corrective Action 3 –
Date: 5.8.23
The charts of all patients at risk of self harm will be audited for compliance for 1:1 continuous observation documentation

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 5/8/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Continuous obs documentation
What is the sample size: 100%
What is the threshold of compliance: 100%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Chief Nursing Officer
What committee in the QAPI program will receive reports on the results: Performance Improvement, Medical Executive Committee and Board Quality

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Deficiency #38

Level: Standard–Level
NU-03: Food Preparation & Storage
Requirement: C
The standard was not met as evidenced by the following
REQUIREMENT C
Observed in the ICU (Location #1) – 4/18/23 @ approximately 1155 by A. Martin
Finding: During a tour of the environment, it was noted that six (6) vital F 1.2 cal. nutritional supplements were found expired as of

4/1/23 and available for use in the patient nutrition area.
Actual / Potential Outcome: Consuming expired nutritional supplements could lead to the potential risk of patient's nutritional needs not being met.
Individual(s) Involved: ICU staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #3

Action Plan

Action #1
The findings were reviewed with the Chief Nursing Officer on 4.27.23, who directed the action plan to be developed.
Actual / Potential Outcome: Consuming expired nutritional supplements could lead to the potential risk of patient's nutritional needs not being met.
Action Plan
Overall responsibility: Chief Nursing Officer; Director of Patient Care Services
Completion Date: 6/16/2023
Description: There will be no expired nutritional supplements on MedSurg or ICU
Corrective Action 1 –
Date 4.20.23
Director of Patient Care Services
Expired supplements removed and discarded

Title of Person Responsible for Implementing the Action: Director of Patient Care Services
Date Action Plan was or will be Implemented: 4/20/2023
Is a Monitoring Plan Required?: No

Action #2
The findings were reviewed with the Chief Nursing Officer on 4.27.23, who directed the action plan to be developed.
Actual / Potential Outcome: Consuming expired nutritional supplements could lead to the potential risk of patient's nutritional needs not being met.
Action Plan
Overall responsibility: Chief Nursing Officer; Director of Patient Care Services
Completion Date: 6/16/2023
Description: There will be no expired nutritional supplements on MedSurg or ICU
Corrective Action 2 –
Date: 6.9.23
Director of Patient care services
Regular inspection of all supplements in patient nutrition areas to commence 6/9/2023
Monitoring Plan
What will be monitored: Patient nutrition areas on MedSurg and ICU
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Weekly for one month then monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Chief Nursing Officer
What committee in the QAPI program: Performance improvement and Board Quality

Title of Person Responsible for Implementing the Action: Director of Patient Care Services
Date Action Plan was or will be Implemented: 6/9/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Patient nutrition areas on MedSurg and ICU
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Chief Nursing Officer
What committee in the QAPI program will receive reports on the results: Performance improvement and Board Quality

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Deficiency #39

Level: Standard–Level
NU-03: Food Preparation & Storage
Requirement: D
The standard was not met as evidenced by the following
REQUIREMENT D
Observed in the Medical Surgical Unit (Location #1) – 4/18/23 @ approximately 1125 by A. Martin
Finding: During a tour of the environment, it was noted that milk was found open and not labeled with an open date or a beyond use date in the patient refrigerator.
Actual / Potential Outcome: Unlabeled food can lead to outdated food items being subsequently consumed which could lead to patient foodborne illness.
Individual(s) Involved: Clinical staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #6

Action Plan

Action #1
The findings were reviewed with the Chief Nursing Officer on 4.27.23, who directed the action plan to be developed.
Actual / Potential Outcome: Unlabeled food can lead to outdated food items being subsequently consumed which could lead to patient foodborne illness.

Action Plan

Overall responsibility: Chief Nursing Officer; Director of Patient Care Services
All unlabeled food should be disposed of. Audits of patient care areas to monitor that food is being labeled with an open date or beyond use date

Title of Person Responsible for Implementing the Action: Chief Nursing Officer
Date Action Plan was or will be Implemented: 5/19/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Dates on patient food
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Chief Nursing officer
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

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Deficiency #40

Level: Standard–Level
NU-06: Ordering of Therapeutic Diets
Requirement: A
The standard was not met as evidenced by the following
REQUIREMENT A
Observed during Survey Activity (Location #1) – 4/20/23 @ approximately 1540 by A. Martin
Finding: Based on information presented at the time of survey, the organization could not substantiate that dietitians who independently order diets and nutritional supplements have been given the authority to do so by the medical staff. In discussions with staff #23, the dieticians are currently ordering diets without a practitioner co-signature. There was no evidence provided that the medical staff had formally recommended and granted the privilege to each dietitian to perform this function. In addition, the medical staff must confirm that it is within a dietitian's scope of practice to independently order diets and supplements in their State.
Actual / Potential Outcome: The medical staff has not given authority for the dieticians to independently order diets.
Individual(s) Involved: Dieticians
Information Source: Discussions with staff #23
Finding Confirmed by: Staff #1

Action Plan

Action #1 The findings were reviewed with the Chief Executive officer on 4.27.23 who directed a corrective action plan be developed and implemented
Actual/potential outcome: The medical staff has not given authority for the dietitians to independently order diets

Action Plan

Date: 4.27.23
Title: Food and Nutrition Services Director
The Registered Dietitian has been directed via email communication on 4/21/23 that they may not independently order diets and

nutritional supplements and that orders must be signed by a Physician. Receipt of this information and understanding was received via email on 4/22/23.

Corrective Action 1

Registered dietitians have been directed that they need a physician order for diets or supplements.
Date: 4/27/23
Description: Diet and supplement recommendations will be given by the dietician to the physician to place the order.

Monitoring Plan

What will be monitored: Nutrition orders
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Director of Quality
What committee in the QAPI program: Performance improvement, Med Exec and Board Quality

Title of Person Responsible for Implementing the Action: Food and Nutrition Services Director
Date Action Plan was or will be Implemented: 4/27/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Nutrition orders
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Director of Quality
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

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Deficiency #41

Level: Standard–Level
DC-04: Discharge Plans Involving Post-Acute Care Services
Requirement: A

The standard was not met as evidenced by the following

REQUIREMENT A
In 2 of 27 records

Observed during Medical Record Review (Location #1) – 4/19/23 @ approximately 1530 by A Martin
Finding: The medical record of Patient #5 was reviewed. It was noted that the patient was discharged to a SNF on 4/14/23. There was no documentation in the record that the patient was provided with a list of SNFs' in the geographic area requested by the patient.
Actual / Potential Outcome: The patient may not be aware of the choices available in selecting a post-acute care provider.
Individual(s) Involved: DC Planner
Information Source: Medical Record
Finding Confirmed by: Staff #1

Observed during Medical Record Review (Location #1) – 4/19/23 @ approximately 1600 by A Martin
Finding: The medical record of Patient #7 was reviewed. It was noted that the patient was discharged to a HHA on 4/14/23. There was no documentation in the record that the patient was provided with a list of HHA's in the geographic area requested by the patient.
Actual / Potential Outcome: The patient may not be aware of the choices available in selecting a post-acute care provider.
Individual(s) Involved: DC Planner
Information Source: Medical Record
Finding Confirmed by: Staff #1

Action Plan

Action #1
The findings were reviewed with the Chief Executive Officer on April 27who directed the action plan be developed.
Actual/Potential Outcome- The patient may not be aware of the choices available in selecting a post-acute care facility

Action Plan

Overall Responsibility- Director Of Quality
Date implemented 5.8.23
Patient choice form implemented for both Skilled Nursing Agencies and Home Health Agencies. Each form lists the available agencies

in the geographic region. The patient is asked to rank their top 3 choices on the form. This is then given to case management to begin referrals and remains part of the medical record.

Corrective Action 1

Title: Patient choice form formulated for Skilled Nursing Agencies. This was discussed at Case Management Staff meeting on 5.2.23 and will be forwarded to forms committee for approval, then implemented.
Date: 5.2.23
Description: The finding was reviewed by Director of Quality.

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 5/8/2023
Is a Monitoring Plan Required?: No

Action #2

Corrective Action 2

Title: Patient choice form formulated for Home Health Agencies. This was discussed at Case Management Staff meeting on 5.2.23 and will be forwarded to forms committee for approval, then implemented.

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 5/8/2023
Is a Monitoring Plan Required?: No

Action #3
Corrective action #3
Auditing for completion of patient choice forms

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Patient choice form completion
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Director of Quality
What committee in the QAPI program will receive reports on the results: Performance improvement and board quality

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Deficiency #42

Level: Standard–Level
DC-04: Discharge Plans Involving Post-Acute Care Services
Requirement: B
The standard was not met as evidenced by the following
REQUIREMENT B
In 3 of 27 files, the following was noted
Observed during Medical Record Review (Location #1) – 4/19/23 @ approximately 1545 by A Martin
Finding: The medical record of Patient #5 was reviewed. It was noted that the patient was discharged to a SNF on 4/14/23. There was no documentation that the organization assisted the patient, family, or the patient's representative in selecting a SNF by using and sharing data on quality measures and data on resource use measures.
Actual / Potential Outcome: Lack of information on quality measures may result in a patient choosing a less than desirable post-acute care provider.
Individual(s) Involved: DC Planner
Information Source: Medical Record
Finding Confirmed by: Staff #1

Observed during Medical Record Review (Location #1) – 4/19/23 @ approximately 1530 by A Martin
Finding: The medical record of Patient #6 was reviewed. It was noted that the patient was discharged to a SNF on 4/12/23. There was no documentation that the patient organization assisted the patient, family, or the patient's representative in selecting a SNF by using and sharing data on quality measures and data on resource use measures.
Actual / Potential Outcome: Lack of information on quality measures may result in a patient choosing a less than desirable post-acute care provider.

Individual(s) Involved: DC Planner
Information Source: Medical Record
Finding Confirmed by: Staff #1

Observed during Medical Record Review (Location #1) – 4/19/23 @ approximately 1600 by A Martin
Finding: The medical record of Patient #7 was reviewed. It was noted that the patient was discharged to a HHA on 4/14/23. There was no documentation that the patient organization assisted the patient, family, or the patient's representative in selecting a HHA by using and sharing data on quality measures and data on resource use measures.
Actual / Potential Outcome: Lack of information on quality measures may result in a patient choosing a less than desirable post-acute care provider.
Individual(s) Involved: DC Planner
Information Source: Medical Record
Finding Confirmed by: Staff #1

Action Plan

Action #1
The findings were reviewed with the Chief Executive Officer on April 27who directed the action plan be developed.
Actual/Potential Outcome- Lack of Information on quality measures may result in patient choosing a less than desirable post-acute care facility

Action Plan
Overall Responsibility- Director Of Quality
Date implemented 5.8.23
Patient choice form implemented for both Skilled Nursing Agencies and Home Health Agencies with website information provided to patient regarding quality measures for agencies. Each form lists the available agencies in the geographic region.

Corrective Action 1
Title: Patient choice form formulated for Skilled Nursing Agencies with information on how to access quality measures for each agency. This was discussed at Case Management Staff meeting on 5.2.23 and will be forwarded to forms committee for approval, then implemented.

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 5/8/2023
Is a Monitoring Plan Required?: No

Action #2

Corrective Action 2
Title: Patient choice form formulated for Home Health Agencies with information on how to access quality measures for each agency. This was discussed at Case Management Staff meeting on 5.2.23 and will be forwarded to forms committee for approval, then implemented.
Date- 5.2.23

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 5/2/2023
Is a Monitoring Plan Required?: No

Action #3

Corrective Action 3
Title- Assisting the patient, family or patient representative by using and sharing data on quality measures will be added to our Organization Policy #DC8610-104 Discharge planning and education on this policy will be given to members of the case management team. This was discussed at Case Management Staff meeting on 5.2.23. Approval through Board of Directors on 6.1.23

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: No

Action #4
Corrective action #4
Auditing of patient choice form with documented assistance to patient accessing quality data

Title of Person Responsible for Implementing the Action: Director of Quality
Date Action Plan was or will be Implemented: 6/2/2023
Is a Monitoring Plan Required?: Yes

Monitoring Plan
What will be monitored: Patient choice form completion
What is the sample size: 100%
What is the threshold of compliance: 90%
How frequently will monitoring occur: Monthly
How long will the monitoring last: 6 months of continuous compliance
Who will oversee the monitoring: Director of Quality
What committee in the QAPI program will receive reports on the results: Performance Improvement and Board Quality

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Deficiency #43

Level: Standard–Level
ED-02: Provision of Emergency Services at Non-Emergency Department Locations
Requirement: B

The standard was not met as evidenced by the following

REQUIREMENT B
Observed during Document Review (Location #2) – 4/18/23 @ approximately 1015 by A. Martin
Finding: Based on information presented at the time of survey, the organization could not substantiate that a current policy is in place that meets the requirements of the standard. Specially, the organization has a facility wide policy to address an emergency response for all locations. However, the policy does not address its offsite location on the availability of staff during an emergency, patient management, and the transfer process.
Actual / Potential Outcome: Lack of policy in this area does not provide clear directions for staff to handle emergent situations and potentially places the patient at risk for an untoward event.
Individual(s) Involved: Leadership
Information Source: Discussion with Staff #1
Finding Confirmed by: Staff #1

Action Plan

Action #1
The findings were reviewed with the Chief Ancillary Officer 5/1/2023 who directed the action plan be developed.
Actual/Potential outcome-Lack of policy in this area does not provide clear directions for staff to handle emergent situations and potentially places the patient at risk for an untoward event.
A new policy will be created that provides a written description of how staff will manage a patient's emergency medical condition. The policy will address the following: ensuring the availability of trained and qualified staff to manage a medical emergency, patient management and the transfer process. Such policy will be written by Chief Ancillary Officer and approved by the Medical Staff as well as the Board of directors on 6.1.23

Title of Person Responsible for Implementing the Action: Chief Ancillary Officer
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: No

Deficiency #44

Level: Standard–Level
LB-01: Provision of Laboratory Services
Requirement: B

The standard was not met as evidenced by the following

REQUIREMENT B
Observed during Document Review (Location #1) – 4/18/23 @ approximately 0945 by A. Martin
Finding: Based on information presented at the time of survey, the organization provides contracted laboratory services as well as waived tests on-site. It was noted that there is no written description of laboratory services provided (both routine and emergent) available to the medical staff.
Actual / Potential Outcome: Lack of identifying availability of routine/emergent laboratory services can potentially delay critical treatment.
Individual(s) Involved: NA
Information Source: Document review.
Finding Confirmed by: Staff #1

Action Plan

Action #1
The findings were reviewed with the Chief Ancillary Officer on 4/27/23 who directed the action plan be developed. Lack of identifying availability of routine/emergent laboratory services can potentially delay critical treatment.
Chief Ancillary Officer
June, 1, 2023

A new policy will be created that provides a written description of laboratory services (both routine and emergent) that must be available to the medical staff. Such policy will be written within 45 days and will be submitted to medical staff committees: Medicine, Surgery and MEC as well as the Board Quality Committee and Board of Directors for review and approval on June 1, 2023
Monitoring not applicable

Title of Person Responsible for Implementing the Action: Chief Ancillary Officer
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: No

Deficiency #45

Level: Standard–Level
LB-02: Provision of Emergency Laboratory Services
Requirement: B

The standard was not met as evidenced by the following

REQUIREMENT B
Observed during Document Review (Location #1) – 4/18/23 @ approximately 0950 by A. Martin
Finding: Based on information presented at the time of survey, the organization could not substantiate that the medical staff has determined which laboratory services are to be immediately available to meet the emergent laboratory needs of patients who may be currently hospitalized or those patients who may present in an emergent condition. The organization has a full menu of laboratory tests available but has not identified those specific tests that are immediately available (i.e., STAT results).
Actual / Potential Outcome: Lack of identifying availability of emergent laboratory services can potentially result in practitioners not understanding when laboratory results are available.
Individual(s) Involved: NA
Information Source: Document review
Finding Confirmed by: Staff #1

Action Plan

Action #1
The findings were reviewed with the Chief Ancillary Officer on 4/27/23 who directed the action plan be developed. Lack of identifying availability of emergent laboratory services can potentially result in practitioners not understanding when laboratory results are available.

Action Plan:

Chief Ancillary Officer
June 1, 23
A new policy will be created that provides a written list of laboratory tests identifying those that are immediately available (i.e. STAT results). Such policy will be written within 45 days and will be submitted to medical staff committees: Medicine, Surgery and MEC as well as the Board Quality Committee and Board of Directors for review and approval. 6/1/2023
Monitoring not applicable

Title of Person Responsible for Implementing the Action: Chief Ancillary Officer
Date Action Plan was or will be Implemented: 6/1/2023
Is a Monitoring Plan Required?: No

Deficiency #46

Level: Standard–Level
LB-03: Management of Tissue Specimens
Requirement: B

The standard was not met as evidenced by the following

REQUIREMENT B
Observed during Document Review (Location #1) – 4/18/23 @ approximately 0955 by A. Martin
Finding: Based on information presented at the time of survey, the organization could not substantiate that a policy had been established identifying specimens requiring only macroscopic examination and specimens that require both macroscopic and microscopic examination.
Actual / Potential Outcome: Lack of policy in this area could lead to misunderstanding of which specimens are required to be microscopically examined to assist with diagnosis.
Individual(s) Involved: NA
Information Source: Document review
Finding Confirmed by: Staff #1

Action Plan

Action #1

The findings were reviewed with the Chief Ancillary Officer on 4/27/23 who directed the action plan be developed. Lack of policy in this area could lead to misunderstanding of which specimens are required to be microscopically examined to assist with diagnosis.

Action Plan

Chief Ancillary Officer
May 1, 2023
Sonoma Valley Hospital contracts with Marin Pathology for Pathology services. An updated policy dated 2021 was provided, see policy #36115.825 Tissue Specimens (Surgical Pathology)
A new policy will be created that states Sonoma Valley Hospital has adopted policy above which provides clarification of specimens requiring both macroscopic and microscopic examination.
Such policy will be written within 45 days and will be submitted to medical staff committees: Medicine, Surgery and MEC as well as the Board Quality Committee and Board of Directors for review and approval. 6/09/2023 Monitoring not applicable

Title of Person Responsible for Implementing the Action: Chief Ancillary Officer
Date Action Plan was or will be Implemented: 6/9/2023
Is a Monitoring Plan Required?: No

Deficiency #47

Level: Standard–Level
RD-01: Provision of Radiology Services
Requirement: D

The standard was not met as evidenced by the following

REQUIREMENT D
Observed in the MRI (Location #1) – 4/19/23 @ approximately 1058 by A. Martin
Finding: During a tour of the environment, it was noted that multiple ferromagnetic objects were noted in MRI Zone III. Specifically, there were two (2) desk chairs, a linen cart, and a large handheld magnet. In discussion with staff, the equipment is not MRI safe nor secured.
Actual / Potential Outcome: Metal objects near MRI machinery could adversely affect equipment and occupants.
Individual(s) Involved: MRI staff
Information Source: Direct observation by surveyor
Finding Confirmed by: Staff #9

Action Plan

Action #1
The findings were reviewed with the Chief Ancillary Officer in an in-person meeting 4/27/2023. Equipment, desk chairs/linen cart/handheld magnet, in Zone III were not secured. Metal objects near MRI machinery could adversely affect equipment and occupants.
Purchase order #93466 order/replace linen cart made of non-ferrous material has been placed with Materials Management. expected delivery before 5/31/2023

Title of Person Responsible for Implementing the Action: Director of Diagnostic Radiology
Date Action Plan was or will be Implemented: 5/31/2023
Is a Monitoring Plan Required?: No

Action #2
Handheld magnet is now stored outside Zone III in an equipment room.

Title of Person Responsible for Implementing the Action: Director of Diagnostic Services
Date Action Plan was or will be Implemented: 5/2/2023
Is a Monitoring Plan Required?: No

Action #3
Replacement of one (visitor) chair made of non-ferrous material has been ordered work order #253680 and will be completed by 5.12.23

Title of Person Responsible for Implementing the Action: Director of Diagnostic Services
Date Action Plan was or will be Implemented: 5/12/2023
Is a Monitoring Plan Required?: No

Action #4
Work Request to tether desk chair has been placed with Facilities work order #253680 completion by 5.12.23

Title of Person Responsible for Implementing the Action: Director of Diagnostic Services
Date Action Plan was or will be Implemented: 5/12/2023
Is a Monitoring Plan Required?: No

Document Tasks By Committee

Listing of currently pending and/or upcoming document tasks grouped by committee.

Sonoma Valley Hospital

Run by: Newman, Cindi (cnewman)
Run date: 05/19/2023 7:29 AM

Report Parameters

Filtered by: Document Set: - All Available Document Sets -
Committee: 07 BOD-Quality (P&P Review)
Include Current Tasks: Yes
Include Upcoming Tasks: No

Grouped by: Committee

Sorted by: Document Title

Report Statistics

Total Documents: 39

Committee: **07 BOD-Quality (P&P Review)**

Committee Members: **Crayton, Monique (mcrayton), Finn, Stacey (sfinn), Newman, Cindi (cnewman)**

Current Approval Tasks (due now)

Document	Task/Status	Pending Since	Days Pending
AccuChek Inform II Glucose Monitoring System *Laboratory Services Policies (LB)*	**Pending Approval**	5/18/2023	1

Summary Of Changes: **Removal of staff name, identified abbreviation and clarified that if test strips are found without cap, they should be discarded as they must be used within 3 minutes.**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Kuwahara, Dawn (dkuwahara), Ramos, Karen (kramos)**

ExpertReviewers: **Medical Director-Lab**

Approvers: **Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Amended Reports 7500-02 *Clinical Lab Dept*	**Pending Approval**	5/18/2023	1

Summary Of Changes: **Changed reference from Paragon to EPIC**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Ramos, Karen (kramos)**

Approvers: **Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Approved Reference Labs 7500-06 *Clinical Lab Dept*	**Pending Approval**	5/18/2023	1

Summary Of Changes: **Removed ARUP and GENZYME laboratories- no longer using facilities**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Ramos, Karen (kramos)**

Approvers: **Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of**

Directors - (Committee)

Audibility of Clinical Monitoring Intervention Alarm Systems | **Pending Approval** | 5/18/2023 | 1

Targeted Quality & Safety Initiatives Policies (QS)

Summary Of Changes: **Reviewed. Only corrected 2 spelling errors. No other changes**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Winkler, Jessica (jwinkler)**

ExpertReviewers: **Medical Director-Patient Care Services**

Approvers: **00 Clinical P&P multidisciplinary review -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Automatic Stop Orders | **Pending Approval** | 5/18/2023 | 1

Medication Management Policies (MM)

Summary Of Changes: **Updated to reflect the terminology and workflow as defined by Epic. Added attachment listing medications that have a review day setting applied to them.**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Kutza, Chris (ckutza)**

Approvers: **01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Care of Unassigned Unaffiliated Metabolic Bariatric Surgery Patients | **Pending Approval** | 5/18/2023 | 1

Patient Care Policy

Summary Of Changes: **Reviewed, minor grammatical changes made**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Sankaran, Sujatha (ssankaran)**

ExpertReviewers: **Winkler, Jessica (jwinkler)**

Approvers: **Hennelly, John (jhennelly) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Code Grey - Aggressive Behavior Management | **Pending Approval** | 5/18/2023 | 1

Emergency Code Alerts Policies

Summary Of Changes: **Updated authors / reviewers names**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Gatenian, Grigory (ggatenian), Drummond, Kimberly (kdrummond)**

ExpertReviewers: **Safety Committee**

Approvers: **01 P&P Committee -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Code Silver - Hostage-Active Shooter | **Pending Approval** | 5/18/2023 | 1

Emergency Code Alerts Policies

Summary Of Changes: **Reviewed policy; Made minor grammatical changes.**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Gatenian, Grigory (ggatenian), Drummond, Kimberly (kdrummond)**

ExpertReviewers: **Safety Committee**

Approvers: **01 P&P Committee -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-**

Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)

Damaged Equipement, Management of *Central Sterile Dept*	**Pending Approval**	5/18/2023	1

Summary Of Changes: **RETIRE:: This is not current workflow and is redundant as this policy exists organizationally. Org policy CE8610-108**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Winkler, Jessica (jwinkler), Cornell, Kelli (kcornell)**

Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Diet Manual *Food (Nutrition) Services Policies (NU)*	**Pending Approval**	5/18/2023	1

Summary Of Changes: **Adding Diet Manual to the Electronic P&P System for the first time. This manual is reviewed annually and approved by the Medical Staff.**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Finn, Bridget (bfinn)**

ExpertReviewers: **Strathman, Melissa (mstrathman)**

Approvers: **Drummond, Kimberly (kdrummond) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Diet Office-Dietitian Availability *Food & Nutrition Services Dept Policies*	**Pending Approval**	5/18/2023	1

Summary Of Changes: **Removed reference to policy 12-16a, removed specifics regarding holiday scheduling of registered dietitian**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Finn, Bridget (bfinn)**

Approvers: **Drummond, Kimberly (kdrummond) -> 01 P&P Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Documentation in the Intensive Care Unit *ICU Dept*	**Pending Approval**	5/18/2023	1

Summary Of Changes: **Re-wrote to reflect the American Association of Critical Care Nurses Scope and Standards of Progressive and Critical Care Nursing Practice; removed references to pediatrics, outdated paper charts, and redundant documentation. Included table of minimal documentation requirements with rationales, spelled out acronyms, streamlined documentation table;**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Winkler, Jessica (jwinkler)**

Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

General Rules for the Safe Use of Radioactive Material new template 7630-151 *Diagnostic Services Dept Policies*	**Pending Approval**	5/18/2023	1

Summary Of Changes: **Added policy purpose**
Reviewed Policy, Updated Authors and Reviewers.

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Young, Dave (dyoung)**

ExpertReviewers: **Medical Director-Diagnostic Radiology**

Approvers: **Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-**

Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)

Hot Lab Requirements 7630-153 | **Pending Approval** | 5/18/2023 | 1

Diagnostic Services Dept Policies

Summary Of Changes: **Updated title.**
Added purpose with definition of hot lab.
Added some clarification and new line with "contracted services" requirements.
Updated author/reviewers.

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Young, Dave (dyoung)**

ExpertReviewers: **Medical Director-Diagnostic Radiology**

Approvers: **Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Informed Consent | **Pending Approval** | 5/18/2023 | 1

Patient Rights Policies (PR)

Summary Of Changes: **Reviewed, no changes**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Winkler, Jessica (jwinkler), Cooper, Kylie (kcooper)**

Approvers: **Sankaran, Sujatha (ssankaran) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Interpreter Services | **Pending Approval** | 5/18/2023 | 1

Targeted Quality & Safety Initiatives Policies (QS)

Summary Of Changes: **Updated the name/reference to the contracted interpreter services and added the various forms of interpretation available.**
Updated the in-house interpreter services available as a secondary option - only utilizing employees who have obtained the Certified Medical Interpreters in clinical situations.
Updated references.

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **McKissock, Lynn (lmckissock)**

ExpertReviewers: **Winkler, Jessica (jwinkler)**

Approvers: **00 Clinical P&P multidisciplinary review -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Line Draws | **Pending Approval** | 5/18/2023 | 1

Laboratory Services Policies (LB)

Summary Of Changes: **Reviewed; Recommend retiring. Ebsco Dynamic Health Procedures offers same policy.**

Moderators: **Newman, Cindi (cnewman)**

Lead Authors: **Ramos, Karen (kramos)**

ExpertReviewers: **Medical Director-Lab**

Approvers: **Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Maggot Debridement Therapy | **Pending Approval** | 5/18/2023 | 1

Wound Care Dept

Summary Of Changes: **Some formatting changes, expansion of abbreviation. Changed owner from CNO to Chief Ancillary Officer**

Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Kuwahara, Dawn (dkuwahara)**
ExpertReviewers:	**Cooper, Kylie (kcooper), Montecino, Stephanie (smontecino)**
Approvers:	**Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Management of Patients in Corridor Locations PC8610-144 — **Pending Approval** — 5/18/2023 — 1

Patient Care Policy

Summary Of Changes:	**Reviewed, no changes**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Brown, Philip (pbrown)**
ExpertReviewers:	**Medical Director-Patient Care Services**
Approvers:	**Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

NEW:: International Dysphagia Diet Standardization Initiative (IDDSI) Nutrition Orders Crosswalk — **Pending Approval** — 5/18/2023 — 1

Food (Nutrition) Services Policies (NU)

Summary Of Changes:	**NEW POLICY** **Sonoma Valley Hospital Food and Nutrition Services department is not currently equipped to follow the International Dysphagia Diet Standardization Initiative (IDDSI). To ensure the appropriate diet textures are provided per physician orders the following crosswalk has been developed.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Finn, Bridget (bfinn)**
ExpertReviewers:	**Strathman, Melissa (mstrathman)**
Approvers:	**Drummond, Kimberly (kdrummond) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

NEW:: MRI With Contrast - Containing Gadolinium — **Pending Approval** — 5/18/2023 — 1

Diagnostic Services Dept Policies

Summary Of Changes:	**NEW POLICY** **Policy was created because Gadolinium MRI contrast is different than iodinated contrast used in Xray and CT.** **The screening criteria, precautions and administration are different enough that a separate policy was needed.** **References to MRI contrast have been removed from the Xray and CT contrast policy.** **The policy adheres to the American College of Radiology guidelines.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Kutza, Chris (ckutza), Young, Dave (dyoung)**
ExpertReviewers:	**Kutza, Chris (ckutza), Medical Director-Diagnostic Radiology**
Approvers:	**Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Nuclear Medicine Department Security — **Pending Approval** — 5/18/2023 — 1

Diagnostic Services Dept Policies

Summary Of Changes:	**Updated policy name to include "Radioactive Material" security since we don't have a traditional Nuc Med department where isotopes are injected.** **Added a Purpose.** **Added detail to several aspects including disposal of waste.** **Updated author, owners and reviewers.** *****Need to correct abbreviation NRC**

Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Young, Dave (dyoung)**
ExpertReviewers:	**Medical Director-Diagnostic Radiology**
Approvers:	**Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Nuclear Medicine Equipment Calibrations — **Pending Approval** — 5/18/2023 — 1

Diagnostic Services Dept Policies

Summary Of Changes:	**Added a Purpose.** **Deleted wording for equipment we don't have.** **Clarified requirements for calibrations.** **Updated author and reviewers.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Young, Dave (dyoung)**
ExpertReviewers:	**Medical Director-Diagnostic Radiology**
Approvers:	**Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Nuclear Medicine Procedures — **Pending Approval** — 5/18/2023 — 1

Diagnostic Services Dept Policies

Summary Of Changes:	**Reviewed Policy, updated details specific to the two NM procedures we do- sentinel node and myocardial.** **Updated author and reviewers.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Young, Dave (dyoung)**
ExpertReviewers:	**Medical Director-Diagnostic Radiology**
Approvers:	**Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Nuclear Medicine Safety Measures — **Pending Approval** — 5/18/2023 — 1

Diagnostic Services Dept Policies

Summary Of Changes:	**Added a Purpose statement.** **Added details to statements.** **Updated to current requirements with using a contracted service for nuclear cardiology procedures.** **Updated author/reviewers.** **Corrected Abbreviation** **Formatting is off and I couldn't get it to number correctly.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Young, Dave (dyoung)**
ExpertReviewers:	**Medical Director-Diagnostic Radiology**
Approvers:	**Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Nuclear Medicine Studies 7630-187 — **Pending Approval** — 5/18/2023 — 1

Diagnostic Services Dept Policies

Summary Of Changes:	**Reviewed policy, updated with current procedure and exams.** **Updated author/reviewers.**

Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Young, Dave (dyoung)**
ExpertReviewers:	**Medical Director-Diagnostic Radiology**
Approvers:	**Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Nutritional Products — **Pending Approval** — 5/18/2023 — 1

Food & Nutrition Services Dept Policies

Summary Of Changes:	**Removed attachments that provided information on specific nutritional products available as this may change more frequently than policy updates and removed reference to attachments. Policy allows for changes to formulary as deemed necessary.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Finn, Bridget (bfinn)**
Approvers:	**Drummond, Kimberly (kdrummond) -> 01 P&P Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Patient's Own Medication Procedure 8390-07 — **Pending Approval** — 5/18/2023 — 1

Pharmacy Dept

Summary Of Changes:	**Made significant changes to accomodate change in workflow with Epic. Clarified responsibility for storing medications to be pharmacist during open hours and nursing supervisor after hours.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Kutza, Chris (ckutza)**
Approvers:	**01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Patient's Rights to Visitation — **Pending Approval** — 5/18/2023 — 1

Patient Rights Policies (PR)

Summary Of Changes:	**Reviewed, no changes**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Cooper, Kylie (kcooper)**
Approvers:	**Winkler, Jessica (jwinkler) -> Hennelly, John (jhennelly) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Personnel Responsibility and Accountability 7500-42 — **Pending Approval** — 5/18/2023 — 1

Clinical Lab Dept

Summary Of Changes:	**Reviewed. Title Change**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Kuwahara, Dawn (dkuwahara), Ramos, Karen (kramos)**
Approvers:	**Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Pulmonary Function Testing — **Pending Approval** — 5/18/2023 — 1

Respiratory Therapy Dept

Summary Of Changes:	**Updated with current equipment references and quality control measures. Added instructions for medication orders and protocols to meet CIHQ standards. Updated reviewer to include Director of Pharmacy and approvals to include P&T Committee.**

Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Young, Dave (dyoung)**
Approvers:	**Kutza, Chris (ckutza) -> Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Recording Nutritional Information in the Medical Records **Pending Approval** 5/18/2023 1

Food & Nutrition Services Dept Policies

Summary Of Changes:	**Removed specific location of documentation in electronic medical record (previous draft utilized Paragon terms that no longer apply since switch to Epic for EMR)**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Finn, Bridget (bfinn)**
Approvers:	**Drummond, Kimberly (kdrummond) -> 01 P&P Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Recording Thermometer Documentation, Failure and Back Up **Pending Approval** 5/18/2023 1

Laboratory Services Policies (LB)

Summary Of Changes:	**Updated to reflect the current practice; reference to policy MM8610-125: Temperature Monitoring of Medication Storage to describe pharmacy process. Reviewed by pharmacy with no suggested changes Correction of staff title and punctuation**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Kuwahara, Dawn (dkuwahara), Cornell, Kelli (kcornell), Ramos, Karen (kramos)**
ExpertReviewers:	**Kutza, Chris (ckutza), Medical Director-Lab, Ramos, Karen (kramos)**
Approvers:	**Winkler, Jessica (jwinkler) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Scope of Services **Pending Approval** 5/18/2023 1

Diagnostic Services Dept Policies

Summary Of Changes:	**Added Purpose and Policy details. Added Scope of Patient Care Needs. Added new Standards of Practice and updated previous standards. Updated author and reviewers Corrected Abbreviations**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Young, Dave (dyoung)**
ExpertReviewers:	**Medical Director-Diagnostic Radiology**
Approvers:	**Kuwahara, Dawn (dkuwahara) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Surgical Case Review **Pending Approval** 5/18/2023 1

Medical Staff Dept

Summary Of Changes:	**Reviewed, no changes**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Sankaran, Sujatha (ssankaran)**
ExpertReviewers:	**Finn, Stacey (sfinn)**
Approvers:	**Cooper, Kylie (kcooper) -> 01 P&P Committee - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Use of Medication Not Procured by the Facility *Medication Management Policies (MM)*	**Pending Approval**	5/18/2023	1

Summary Of Changes:	**Made minor formatting changes. Updated name and process for patient belongings documentation in the medical record to match Epic. Removed detailed process for how pharmacy handles patient's own medications to be stored as this is addressed in a separate department policy/procedure.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Kutza, Chris (ckutza)**
Approvers:	**01 P&P Committee -> 04 MS-Performance Improvement/Pharmacy & Therapeutics Committee - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Utilization Review Plan *Utilization Review Policies (UR)*	**Pending Approval**	5/18/2023	1

Summary Of Changes:	**Reviewed, no changes.**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Cooper, Kylie (kcooper)**
Approvers:	**Sankaran, Sujatha (ssankaran) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Vapotherm High Flow System *Respiratory Therapy Dept*	**Pending Approval**	5/18/2023	1

Summary Of Changes:	**Changed department to Resp. Therapy; Updated equipment name to Vapotherm Precision Flow; Added "the purpose of this policy...." statement. Minor grammatical corrections; Updated link to Vapotherm website**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Winkler, Jessica (jwinkler)**
Approvers:	**00 Clinical P&P multidisciplinary review -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

Visits, Admissions, Readmissions, Transfers Through the Emergency Department *Patient Care Policy*	**Pending Approval**	5/18/2023	1

Summary Of Changes:	**Reviewed, no changes**
Moderators:	**Newman, Cindi (cnewman)**
Lead Authors:	**Sankaran, Sujatha (ssankaran)**
ExpertReviewers:	**Winkler, Jessica (jwinkler)**
Approvers:	**Hennelly, John (jhennelly) -> 01 P&P Committee - (Committee) -> 02 MS-Medicine Department - (Committee) -> 03 MS-Surgery Department - (Committee) -> 05 MS-Medical Executive - (Committee) -> 07 BOD-Quality (P&P Review) - (Committee) -> 09 BOD-Board of Directors - (Committee)**

SUBJECT: International Dysphagia Diet Standardization Initiative (IDDSI) Nutrition Orders Crosswalk	POLICY: NU8610-300
	Page 1 of 3
DEPARTMENT: Organizational	EFFECTIVE: 2023
REVISED:	

NEW POLICY

Sonoma Valley Hospital Food and Nutrition Services department is not currently equipped to follow the International Dysphagia Diet Standardization Initiative (IDDSI). To ensure the appropriate diet textures are provided per physician orders the following crosswalk has been developed.

WHY:

Diet orders and changes to diet orders are received via electronic medical records communication utilizing IDDSI terminology for all patients who will be receiving food while in Sonoma Valley Hospital. This is interfaced with MealSuite utilizing MealSuite Connect. MealSuite will receive the diet order from the electronic medical records software and will convert IDDSI diet order to NDD diet order following the crosswalk below:

OWNER:
Chief of Support Services

AUTHORS/REVIEWERS:
Director of Food & Nutrition Services
Registered Dietitian
Board Quality Committee

SUBJECT: International Dysphagia Diet Standardization Initiative (IDDSI) Nutrition Orders Crosswalk	POLICY: NU8610-300
	Page 2 of 3
DEPARTMENT: Organizational	EFFECTIVE: 2023
REVISED:	

PURPOSE:
Sonoma Valley Hospital Food and Nutrition Services department is not currently equipped to follow the International Dysphagia Diet Standardization Initiative (IDDSI). To ensure the appropriate diet textures are provided per physician orders the following crosswalk has been developed.

POLICY:

Diet orders and changes to diet orders are received via electronic medical records communication utilizing IDDSI terminology for all patients who will be receiving food while in Sonoma Valley Hospital. This is interfaced with MealSuite utilizing MealSuite Connect. MealSuite will receive the diet order from the electronic medical records software and will convert IDDSI diet order to NDD diet order following the crosswalk below.

Dietary staff will reference the approved crosswalk as needed to confirm the correct diet is being provided to the patient in accordance with the physician's orders.

PROCEDURE:

Crosswalk

EPIC Order (PHYSICIAN)	**MealSuite**
SOLIDS	**Covert To:**
Regular or Easy to Chew 7 (RG7/EC7)	Regular
Soft & Bite Size 6 (SB6) or Diet Dysphagia; Soft & Bite Sized (SB6)	Mechanical Soft
Minced & Moist 5 (MM5) or Diet Dysphagia; Minced & Moist 5 (MM5)	Mechanical Soft
Pureed (PU4) or Diet Dysphagia; Pureed 4 (PU4)	Pureed
LIQUIDS	
Extremely Thick 4 (EX4)	Pudding Thick Liquids
Moderately thick 3 (MO3)	Honey Thick Liquids
Mildly Thick 2 (MT2)	Nectar Thick Liquids
Slightly Thick 1	Nectar Thick Liquids
Thin (TN0)	Thin Liquids

SUBJECT: International Dysphagia Diet Standardization Initiative (IDDSI) Nutrition Orders Crosswalk	POLICY: NU8610-300
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DEPARTMENT: Organizational	EFFECTIVE: 2023
REVISED:	

REFERENCES:
International Dysphagia Diet Standardization Initiative (IDDSI)
MealSuite Connect

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SUBJECT: MRI With Contrast -Containing Gadolinium	POLICY: 7630-300
	Page 1 of 6
DEPARTMENT: Medical Imaging	EFFECTIVE:
REVISED:	

PURPOSE:

- Ensure contrast administration is performed according to hospital and departmental protocols with appropriate supervision by a licensed independent practitioner (LIP).
- Ensure appropriate actions are undertaken in case of contrast reactions and extravasation of contrast.
- Ensure laboratory testing requirements are conducted in patients in whom contrast administration is considered and meet screening requirements.

Key point: Gadoteridol (ProHance®) *is the standard gadolinium containing contrast medium used at Sonoma Valley Hospital for all patients, including those that are deemed high risk for nephrogenic systemic fibrosis (NSF). ProHance® is a* ***Group II*** *contrast agent.*

POLICY:

Licensed Radiologic Technologists that have had the necessary instruction and are certified to perform venipuncture are able to access and administer MRI intravenous (IV) contrast media under the supervision of a licensed practitioner (LIP) and in accordance with the procedure defined in this policy and following protocols used for contrast administration that are based on the type of examination ordered and define the type, dose and route of contrast.

1. Gadolinium-based contrast agents (GBCAs) should only be administered when deemed necessary by the radiologist.
2. ***Routine screening and laboratory testing for renal failure is no longer required prior to the administration of group II agents.***
3. If a patient presents with known renal failure, the necessity of a group II agent should be confirmed by the radiologist.
4. ***Group I agents*** are contraindicated in patients on dialysis and are <u>not</u> used at SVH.
5. ***Group III agents*** (Eovist®) require informed consent when eGFR < 30.

	eGFR ≥ 30	**eGFR < 30**
Group II GBCA (ProHance®)	Single/multiple dose appropriate	Confirm necessity of GBCA

Group III GBCA (Eovist®)	Single dose appropriate	Informed consent needed

- The relative risk to benefit of intravenous gadolinium in patients with severely impaired kidney function should be carefully considered by the referring physician and radiologist, with input from a nephrologist if necessary. Particular caution should be considered in patients with acute renal failure or evidence of co-existing severe liver disease. ***No patient should be denied any imaging investigation that is critical to clinical management*.**

- Outpatient
  - No informed consent or screening form is required for outpatient administration of ***group II agents***, regardless of the estimated glomerular filtration rate (eGFR). As stated by the American College of Radiology (ACR): "Given the very low, if any, risk of NSF development with group II agents, ***regardless of renal function or dialysis status, informed consent is not recommended*** prior to GBCA group II injection.. ."

- Inpatient
  - If there is known renal failure with an eGFR < 30 in an inpatient, a radiologist must confirm the need for GBCAs before proceeding with MRI.

    Key point: *Gadolinium should only be given to an inpatient with GFR < 30 if MRI with contrast is considered necessary for clinical management.*

- Multiple Doses
  - There is no contraindication to the use of multiple doses of GBCAs in a short time-period if deemed necessary for clinical management, although group II agents are strongly recommended in patients at risk for NSF.

- If no alternative imaging technique is possible in a patient with an eGFR < 30, and a contrast enhanced MRI with a ***group III agent*** is considered critical to patient care, informed consent should be obtained by the attending radiologist.

PROCEDURE:

Group II Agents

For Group II agents (e.g. **ProHance**®), screening for renal failure and laboratory testing of eGFR will no longer be routinely performed for outpatients. This reflects recent data and the latest ACR Manual on Contrast Media, which states that "the risk of NSF among patients exposed to standard or lower than standard doses of group II gadolinium-based contrast agents ***is sufficiently low or possibly nonexistent*** such that assessment of renal function with a questionnaire or laboratory testing is optional prior to intravenous administration."

The supervising LIP or his/her physician designee must be available to respond promptly to an adverse event related to contrast administration.

An LIP reviews all requests for radiology procedures with intravenous contrast to determine and/or modify the appropriate protocol based on the clinical indications for the examination and patient status. The assigned protocol is indicated in the radiology information system (RIS) or electronic medical record (EMR).

For those procedures where a contrast protocol has been established and approved by the Pharmacy and Therapeutics committee, the technologist may administer the contrast, following the established protocol, using a protocol order.

Type of contrast and dose information is recorded in the EMR by the technologist.

Store at 77°F. Manufacturer acceptable range is 59°F to 86°F. Protect from light.

Group I and Group III Agents

Group I agents are no longer used at SVH. For group III agents (e.g., **Eovist**®), laboratory results should be checked for the most recent serum creatinine (by the technologist performing the study). For patients with the following risk factors, serum creatinine with calculation of eGFR should be performed **within 6 weeks** for outpatients and **within 7 days** for inpatients of the MRI study:

- History of "kidney disease" as an adult, including renal tumor or transplant.
- Diabetes treated with insulin or other prescribed medications.
- Hypertension (high blood pressure) requiring medication.
- Multiple myeloma.
- Solid organ transplant.
- History of severe hepatic disease/liver transplant/pending liver transplant. For these patients, GFR assessment should be contemporaneous with the MRI.

Estimated Glomerular Filtration Rate (eGFR) is calculated using the serum creatinine. In those patients who have known chronic kidney disease (CKD) or other risk factors for contrast-induced nephropathy (CIN) as noted above, the referring provider should place a new order for serum creatinine at the time the examination is ordered if the most recent creatinine will be greater than 6 weeks old for outpatients or greater than 7 days old for inpatient.

- Prior to Injection:
  - Make positive identification of all contrast media before infusion. Check label before drawing up and again before injection.
  - Make positive identification of the patient prior to the injection in adherence to the department's patient identification policy.
  - Medication lists, orders, protocols and other pertinent information/paperwork are scanned into EMR, PACS or RIS for document archival.
- Administration of GBCA for various MR exams (adult and pediatric):
  - Contrast enhanced MRI exams are performed with a single dose IV ProHance® (gadoteridol) using 0.1 mmol/kg (0.2 mL/kg) body weight.
    - Some contrast enhanced MRI and MRA exams may be performed with doses of IV ProHance® (gadoteridol) as defined by the radiologist.
- Injection:
  - Ensure the 5 rights for medication administration are satisfied.
    - Check the following:
      1. Patient identification with at least two patient identifiers to ensure the right patient,
      2. The right contrast (medication),
      3. The right dose,
      4. The right route,
      5. The right time.
  - Ensure that a supervising radiologist, ED physician or licensed independent practitioner (LIP) is available before injection is started.

- A short peripheral IV catheter in the antecubital or forearm area is the preferred route for contrast administration. Use a new tourniquet and alcohol swab. Wipe with a Chloraprep swab prior to the alcohol swab.

- Have a tegaderm dressing and tape available to hold the angiocath in place.

- A saline test flush may be used to test the power injection. Standard procedures should be used to clear the syringe and pressure tubing of air before connecting to the catheter.

- The IV site will be monitored for extravasation during injection. If extravasation is detected, the injection is stopped immediately.

- Advise patients with kidney disease to contact a healthcare professional if any of the following symptoms occurs after receiving a GBCA: burning, itching, swelling, scaling, hardening and tightening of the skin; red or dark patches on the skin; stiffness in joints with trouble moving, bending or straightening the arms, hands, legs or feet; pain in the hip bones or ribs; or muscle weakness.

- In the event of any reaction or extravasation, notify the radiologist or Emergency Department physician immediately. Complete an event report as soon as reasonably possible or by the end of your shift.

- Observe the patient at all times until the patient's release.

Role of dialysis after gadolinium administration in patients with renal impairment

- The risk of NSF is extremely low when group II agents are used in the setting of dialysis. Dialysis after GBCA administration, however, does not protect patients from developing NSF. Studies have shown that the serum concentration of gadolinium is significantly decreased after hemodialysis, but there is no information regarding residual tissue amounts. Theoretically, the sooner the dialysis session is performed the less amount of contrast agent is deposited in the tissues. Therefore, all patients already receiving dialysis treatment should be scheduled for hemodialysis as soon as practical following the gadolinium-enhanced MRI and preferably within 24 hours. Patients receiving peritoneal dialysis do not need to be switched to hemodialysis.

- Dialysis should be arranged by the requesting physician in consultation with the patient's outpatient nephrologist and dialysis unit. Routine MRI studies should be scheduled in the morning and dialysis scheduled in the afternoon following the study; radiology scheduling staff will give morning slot priority to dialysis patients. Administration of

dialysis promptly after gadolinium may require altering the patient's regular outpatient dialysis schedule and advance communication several days in advance with the nephrologist and dialysis unit. There is general consensus that a patient with chronic kidney disease who is not already dialysis dependent should not be started on dialysis after administration of gadolinium for precautionary purposes only, since there is no data to support the benefits of this intervention.

Key point: Dialysis should preferably be performed within 24 hours of gadolinium administration to patients already on dialysis. The institution of dialysis is not required in patients with severe renal impairment who are not already on dialysis after gadolinium administration.

REFERENCE:
ACR Manual on Contrast Media, 2020. ACR Committee on Drugs and Contrast Media.

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